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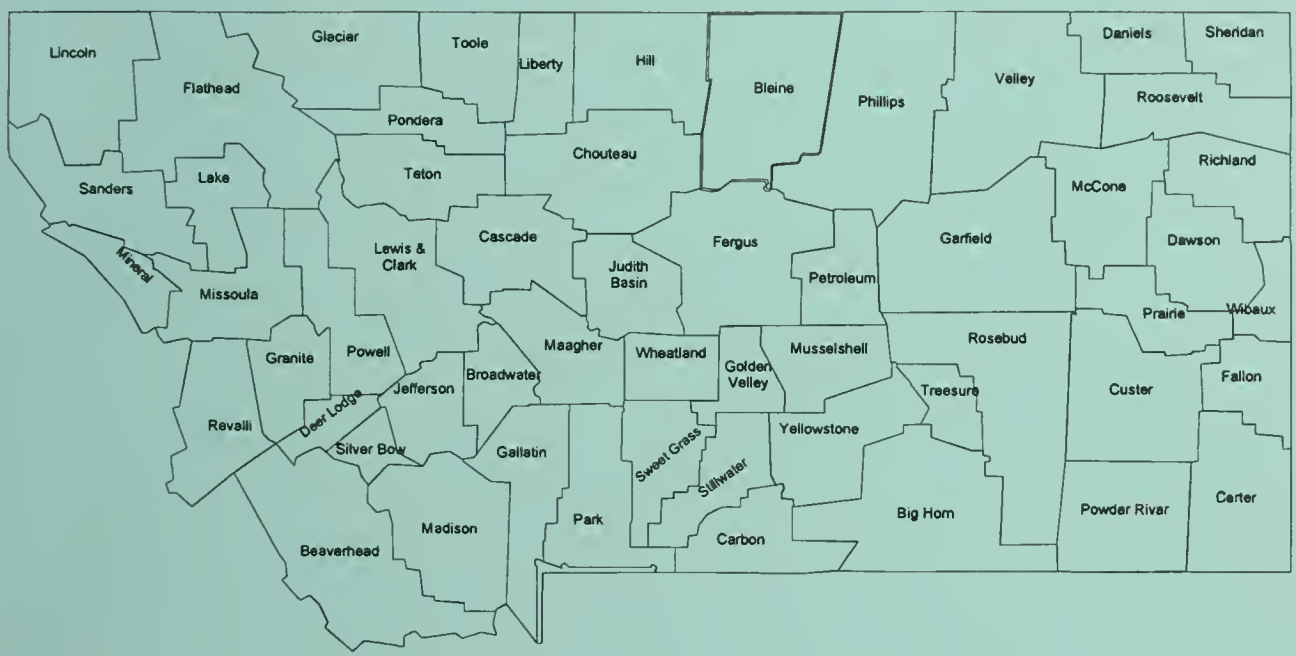
The Montana Medicaid Program

Annual Report for 1997 and Report to the Legislature for the 2000 - 2001 Biennium



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Laurie Ekanger, Director

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The Montana Medicaid Program

Annual Report for 1997

The Montana Medicaid Program is authorized under 53-6-101 MCA and article XII, sec 3 of the Montana Constitution. The program is administered by the Department of Public Health and Human Services.

Program Management

Nancy Ellery, Administrator
Health Policy & Services
444 - 4141

Dan Anderson, Administrator
Addictive & Mental Disorders
444 - 3969

Mike Hanshew, Administrator
Senior and Long Term Care
444 - 4077

Joe Mathews, Administrator
Disability Services
444 - 2591

Hank Hudson, Administrator
Child & Family Services
444 - 5901

Denzel Davis, Administrator
Quality Assurance Division
444 - 5401

Program Mission: To assure that necessary medical care is available to all eligible low income Montanans

Basic Objectives

To promote the maintenance of good health by program recipients

To assure recipients have access to necessary medical care

To assure that quality of care meets acceptable standards

To promote the appropriate use of services by recipients

To assure that services are provided in a cost effective manner

The Montana Medicaid Program

Annual Report for 1997 and Report to the Legislature for the 2000 - 2001 Biennium

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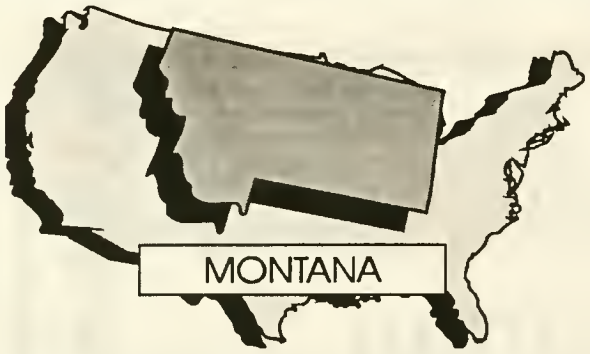
Medicaid Program

Program Changes & Quality Improvements



Medicaid Program

Resource Based Relative Value System (RBRVS) Approved:

The 1997 legislature approved the conversion to the Medicare resource based relative value scale (RBRVS) which calculates reimbursement based on the value of a service relative to all other services. This is accomplished by comparing the resources (office expenses, malpractice insurance and provider work effort & complexity) needed to perform a specific service to those needed for another service. Each service code is then assigned a relative value unit (rvu) designating its position on the relative value scale. The fee for each code is determined by multiplying the rvu by a conversion factor with a dollar value. The conversion factor is Montana specific to insure the overall budget neutrality of the Medicaid appropriation.

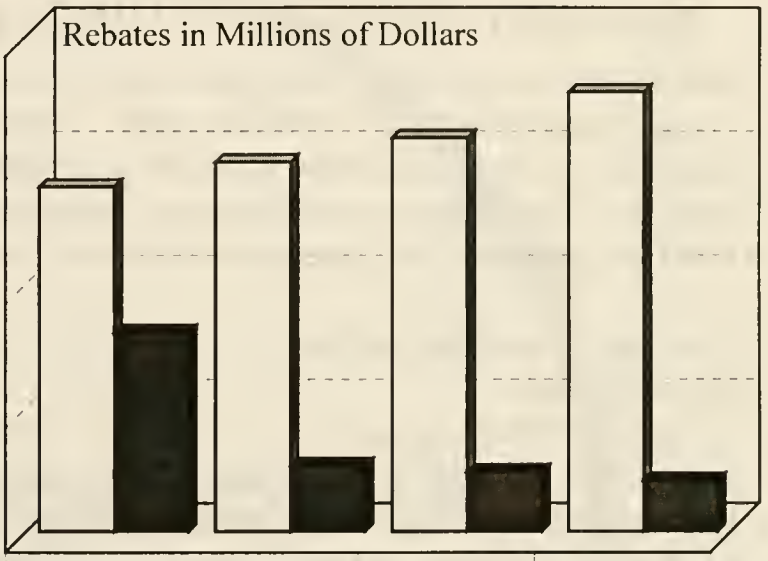
Mental Health Managed Care Implemented:

The Mental Health Access Plan (MHAP), the state's managed mental health care program, was implemented on April 1, 1997. The federal HCFA waiver that enables the program requires that a payment be made on a per capita basis for all Medicaid recipients. Therefore, all Medicaid eligible individuals are entitled to receive services if a determination of mental illness exists. Since the programs inception in 1997, the number of Medicaid eligible individuals has decreased from approximately 72,500 to roughly 67,000 in the fall of 1998. The decrease has been due largely to the success of Montana's FAIM welfare reform initiative. The contract is managed by Montana Community Partners which is jointly operated by Magellan Health Services and Montana mental health providers.

Medicaid Program

Drug Rebate Collections Enhanced in 1997:

Beginning August 1997, the Department dedicated a full-time equivalent staff member to coordinate the Medicaid drug rebate and dispute resolution program. As a result, the Department has observed a 11.6% increase in rebate collections and a 14% decrease in disputed billing in FY 98 as compared to FY 97. Specifically, the Department collected $7,092,947 in FY 98 compared to $6,356,130 in FY 97, and the average amount in dispute each quarter decreased from $958,320 in FY 97 to $818,045 in FY 98. Overall, the State received $736,817 more in rebates in FY 98 than in FY 97. The figure below shows the change in rebates billed, collected, and disputed from FY 95 through FY 98.



	1995	1996	1997	1998
$ Collected □	$5.56	$5.96	$6.35	$7.09
$ Disputed ■	$3.22	$1.06	$0.96	$0.82

Innovative New Reimbursement System Implemented for Outpatient Hospital Services:

The department implemented a new reimbursement system beginning in July, 1995 for Medicaid outpatient hospital services. The new system, called a prospective payment system, pays hospitals similar amounts for similar services and replaces a cost based system. One of the primary features of the new system is the Day Procedure Group (DPG) which classifies surgical procedures into 66 different groups for payment purposes. Montana's small rural hospitals are exempt from the new payment methodology and continue to be paid based on cost to help ensure their financial feasibility. The new payment system provides hospitals with incentives to be efficient, and allows the department to exercise greater control over the rate of outpatient hospital expenditures for the Medicaid program.

Medicaid Program

New Medicaid Management Information System (MMIS) implemented in 1997:

Consultec, Incorporated was awarded the contract to implement a new claims processing system in November 1995. Since Consultec was already the State's fiscal agent, it was not necessary to install a completely new system, so an enhanced version of the Medicaid Management Information System (MMIS) was installed in May 1997 according to requirements specified by the State.

The new system addressed a number of key issue during implementation. These issues include:

1. Year 2000 Compliance: Consultec's system was designed in anticipation of the need to be Year 2000 compliant. All Y2K issues were addressed during the design and development of the new MMIS, and all testing will be completed by March 1999.
2. Provider Re-enrollment: Prior to the implementation of the new system, the Department and Consultec re-enrolled all providers to ensure that the provider file is accurate and complete.
3. Improved response to Requested System Changes: All of the programming staff is now located on site in Helena, rather than at the corporate office in Atlanta. With staff dedicated to Montana Medicaid, system changes are implemented in a more timely and responsive manner.

In June 1998, representatives from the Health Care Financing Administration (HCFA) performed an on-site review of all of the functionality of the MMIS for certification. The MMIS was federally certified with only one minor issue cited.

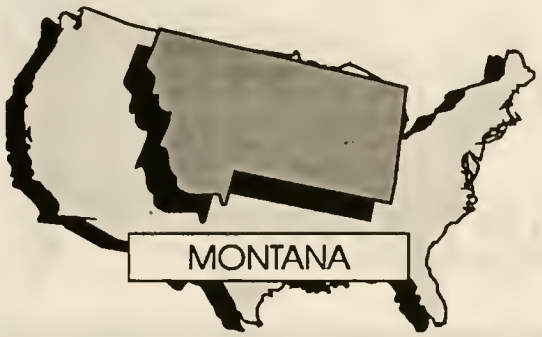
Medicaid Program

What Programs Do We Offer?

Medicaid Program

Program Overview:

Program	Funding	Who's Eligible?	% of Medicaid Program
Title XIX: Medicaid Categorically Needy	69.1% Federal 30.9% State	Receives, or is eligible to receive, cash assistance (TANF or SSI). Aged, Blind, Disabled Including Institutional clients. Pregnant women to 133% of the federal poverty level (FPL). Children to 100% of the FPL.	Fy 1997: These eligibles accounted for 45.7% of Medicaid Expenditures.
Title XIX: Medicaid Medically Needy	69.1% Federal 30.9% State	Meet categorical requirements, but have excess resources or income. Must spend excess income on medical care before eligible. Characterized by critical medical needs and/or high medical bills.	Fy 1997: These eligibles accounted for 29.6% of Medicaid Expenditures.
Title XIX: Medicaid Indian Health Services	100% Federal	Native Americans who are also eligible for Medicaid. Services received from the IHS or other authorized tribal sponsored medical care.	Fy 1997: These eligibles accounted for $14.1 Million of Medicaid Expenditures.



Medicaid Program

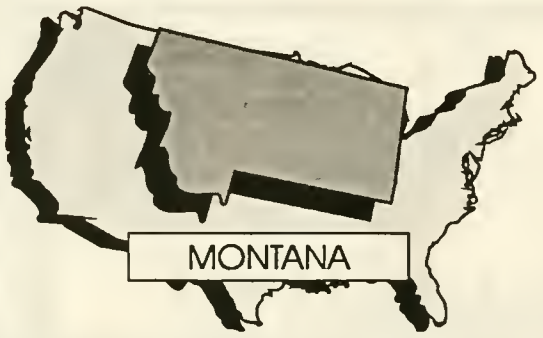
Medicaid and Families Achieving Independence in Montana (FAIM):

There are no changes under Montana's welfare reform in service coverage for children, pregnant women, the elderly, or the disabled.

FAIM requires employable adults:

-to participate in a Health Maintenance Organization (HMO) in the geographic areas where an HMO is available (participation in "Passport to Health," Montana's managed health care program, is mandatory for Basic Medicaid recipients in the geographic areas where no HMO is available), and

-to receive a basic Medicaid package which excludes dental, eyeglasses/optometric services, durable medical equipment, personal care attendants, and hearing aid/audiology services. Excluded services may be provided if required for a job or in emergency situations.



Medicaid Program

Family Programs

Families with Dependent Children: Families with income and resources below the TANF (Temporary Assistance to Needy Families) Limits may receive both TANF cash benefits and Medicaid or they may receive Medicaid only.

TANF Families: This program provides a monthly assistance check to families who are eligible for TANF benefits. As with other public assistance programs, eligibility is based on income and resources and certain other program requirements. Families are required to enter into a Family Investment Agreement which outlines activities intended to help the family move toward employment. Intensive case management, job training, work experience and referral to community resources can be provided to TANF families. Cash assistance benefits are available for a maximum of 60 months, so the program emphasizes rapid employment with the help of supportive programs such as child care assistance, food stamps, child support collection services, and Medicaid.

Transitional Medicaid: Under certain conditions, families are eligible for an additional 12 months of extended Medicaid coverage after cash assistance has been terminated.

Number of Persons	Monthly Income Limit
1	$1,241
2	$1,673
3	$2,104
4	$2,536
5	$2,968
6	$3,399
7	$3,831
8	$4,263
9	$4,694

Medicaid Program

Pregnant Women

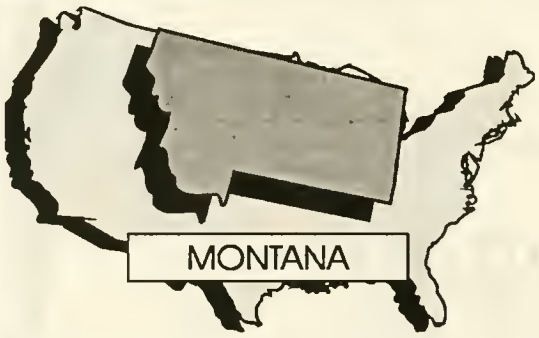
Many low-income pregnant women are eligible for Medicaid. The program has resource limit of $ 3,000 and an income limit based on 133% of the FPL.

Low Birth Weight (LBW) babies are often extremely costly in terms of direct medical expenses, but in the longer term LBW is associated with childhood morbidities such as neurological problems, mental retardation, learning disorders and respiratory tract infections.

Number of Persons	Income Limit 133% of FPL
1	$892
2	$1,203
3	$1,513
4	$1,823
5	$2,134
6	$2,444
7	$2,754
8	$3,065
9	$3,375
10	$3,685

The MIAMI program and other public health programs provides a variety of services before, during and after pregnancy.

Unintended Pregnancy is Expensive: $7,072 is the average cost for prenatal care, labor, and delivery, compared to approximately $400 per person per year for family planning services.



Medicaid Program

Children's Programs

Medicaid is the largest provider of health care coverage for children in the State of Montana. The program covered 62,047 children in 1997. Children's coverage is provided through several eligibility criteria as described below:

Children under TANF: Under TANF children through age 19 are eligible for Medicaid if family income is below 40.5% of the Federal Poverty Level (FPL). Children under TANF are eligible for full Medicaid coverage.

Infants and Children through Age 5: These children are provided with full coverage under the Medicaid program at 133% of the Federal Poverty Level.

Other Children: Federal OBRA 89 required states to implement the minimum "phase in" coverage for children from age 6 through 18 at 100% of the federal poverty level. States had the option to accelerate coverage under this legislation. Montana chose the "phase in" option and in 1997 covered children ages 6 through 13 at 100% of the FPL. In 2002 Montana Medicaid will cover all children 18 and under and in families earning up to 100% of the federal poverty level.

Under the Federal Early Periodic Screening, Diagnosis & Treatment (EPSDT) legislation, states are required to provide children with any medically necessary service regardless of whether that service is part of the state plan package of approved services.

Family Size	40.5% FPL	100% FPL	133% FPL
1	$272	$671	$892
2	$366	$904	$1,203
3	$461	$1,138	$1,513
4	$555	$1,371	$1,823
5	$650	$1,604	$2,134
6	$744	$1,838	$2,444
7	$838	$2,071	$2,754
8	$933	$2,304	$3,065

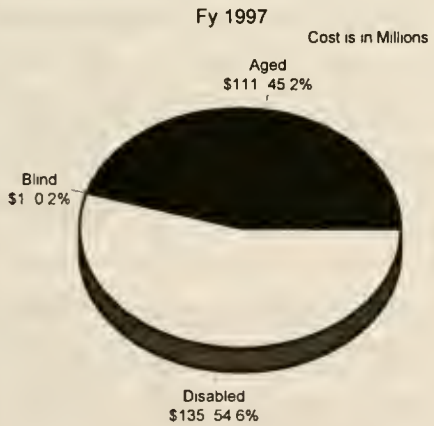
Medicaid Program

Aged, Blind, and Disabled

Low income aged and disabled persons make up a large group within the Medicaid program. Many aged SSI clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. Medicaid is critical to maintaining access to medical care and thereby supports a higher level of independence, often reducing the need for more costly medical and support services.

Persons with income and resources below federal SSI limits may receive both SSI cash benefits and Medicaid or they may receive Medicaid only. The Department's Disability Determination Bureau determines eligibility for the SSI program. Aged, blind or disabled persons with income and/or resources above the SSI limits may be eligible for Medicaid under the Medically Needy program.

Aged, Blind and Disabled



The aged, blind and disabled are an extremely high cost population. The chart at left reflects the total cost for each group. It should be noted that 74% of total Medicaid expenditures relate to services provided to persons in these aid categories each year.

Number of Persons	Resource Limit	Income Limit
1	$2,000	$494
2	$3,000	$741

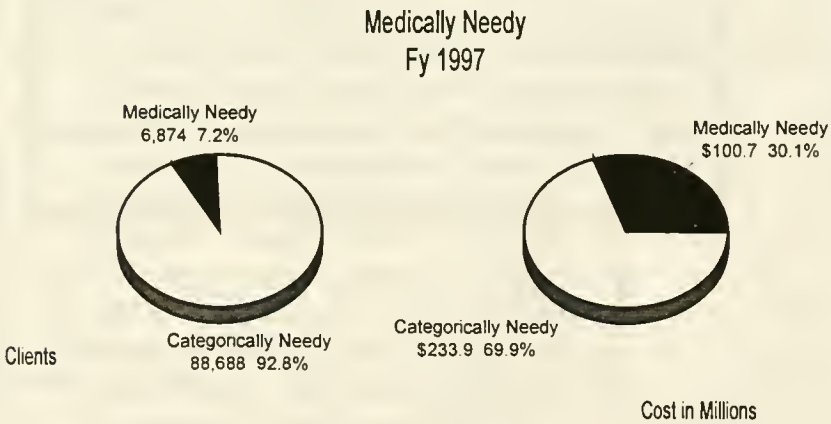
Medicaid Program

Medically Needy

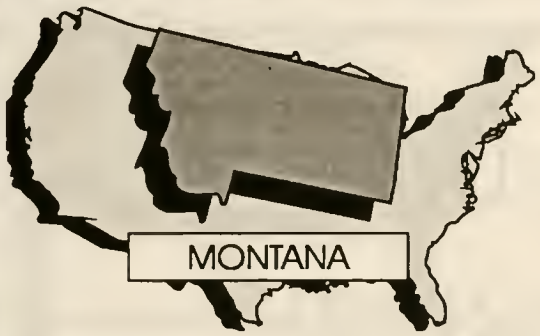
Medically Needy is a federally matched Medicaid program for persons with income or resources above the categorical limits. Medically needy is an optional program that was established by the legislature.

Clients with income and resources above categorical limits are required to spenddown their excess income before eligibility can be established and payments made. The client spends down the excess income by incurring medical bills equal to the spenddown. The client is responsible for these bills during the spenddown period.

In 1997, 64% of expenditures for the medically needy were for nursing home costs.



Number of Persons	Resource Limit	Income Limit
1	$2,000	$491
2	$3,000	$491
3	$3,000	$523
4	$3,000	$555
5	$3,000	$650
6	$3,000	$744
7	$3,000	$838
8	$3,000	$933
9	$3,000	$980
10	$3,000	$1,024



Medicaid Program

Indian Health Services

The Montana Medicaid Program provides reimbursement for medical services rendered to Medicaid eligible Native Americans who receive medical services through the Indian Health Services (IHS) facilities or other approved tribal providers. By law, the Medicaid program acts as the "pass through" agency for these services which are funded with 100% federal funds.

Medicaid reimburses outpatient IHS services on an all-inclusive encounter basis and pays for inpatient services using a per diem payment. The fiscal 1999 reimbursement rates are $152 and $760 for outpatient and inpatient services, respectively. These rates are established by the federal government.

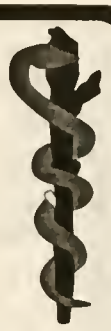
Year	Reimbursement
1993	$4,000,000
1994	$6,000,000
1995	$8,000,000
1996	$11,000,000
1997	$14,000,000
1998	$15,800,000

The Department contracts with the IHS to provide services at the following ten locations in Montana: Browning, Crow Agency, Harlem, Lodgegrass, Poplar, Hays, Heart Butte, Pryor, Lame Deer, and Wolf Point. The facilities at Browning, Crow Agency and Harlem provide both inpatient and outpatient services. All other facilities provide only outpatient services. The Department also contracts separately for services at the Rocky Boy reservation since they are a self governing tribal entity. The Confederated Salish-Kootenai tribe, which is also a self governing tribal entity, is enrolled in the Medicaid program as a Federally Qualified Health Center (FQHC) and is paid in accordance with the Medicaid FQHC rules.

Medicaid Program

Who and Where are our Clients?

Medicaid Program

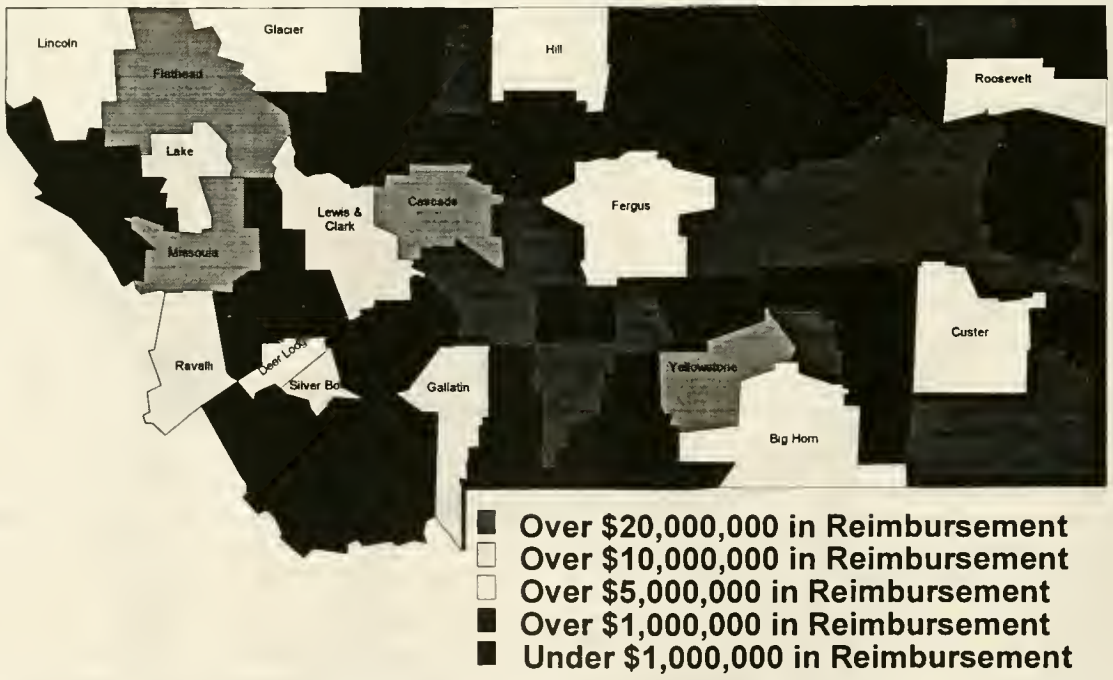


County	# of Eligibles	Expenditures	Population (1992)	Per Capita Spending	% On Medicaid
Beaverhead	923	3,730,620	8,603	$433.64	10.7
Big Horn	3,133	6,179,756	11,661	$529.95	26.9
Blaine	1,684	2,991,823	6,777	$441 47	24.9
Broadwater	483	1,278,665	3,520	$363.26	13.7
Carbon	667	3,161,941	8,253	$383.13	8.1
Carter	109	557,977	1,489	$374.73	7.3
Cascade	9,305	31,931,777	79,268	$402.83	11.7
Chouteau	323	2,105,246	5,459	$385 65	5.9
Custer	1,670	6,843,087	11,763	$581.75	14.2
Daniels	103	483,738	2,128	$227.32	4 8
Dawson	788	2,683,923	9,064	$296.11	8.7
Deer Lodge	1,748	5,706,503	10,037	$568.55	17 4
Fallon	225	1,647,055	3,016	$546.11	7.4
Fergus	1,441	5,836,296	12,407	$470.40	11.6
Flathead	7,718	23,586,638	62,857	$375.24	12.3
Gallatin	3,448	10,736,046	53,875	$199.28	6.4
Garfield	58	336,408	1,428	$235.58	4
Glacier	3,976	6,316,319	12,189	$518.20	32.6
Golden Valley	78	264,996	897	$295 42	8.6
Granite	316	1,082,676	2,531	$427.77	12.5
Hill	2,777	7,754,277	17,799	$435.66	15.6
Jefferson	801	2,491,288	8,248	$302.05	9.7
Judith Basin	200	220,198	2,251	$97.82	8.9
Lake	4,316	12,335,709	22,051	$559 42	19.6
Lewis & Clark	5,647	15,898,464	49,661	$320.14	11.4
Liberty	65	458,955	2,255	$203.53	2.8
Lincoln	3,183	8,176,290	17,682	$462.41	18
Madison	410	1,705,784	6,070	$281.02	6.7
McCone	100	741,812	2,099	$353.41	4.7
Meagher	175	862,358	1,813	$475.65	9.6
Mineral	698	1,549,846	3,465	$447.29	20.1
Missoula	10,112	29,824,175	82,416	$361.87	12.2
Musselshell	533	2,043,902	4,103	$498.15	12.9
Park	1,348	4,569,108	14,786	$309.02	9.1
Petroleum	35	51,951	511	$101.67	6.8
Phillips	566	1,984,298	5,090	$389.84	11.1
Pondera	985	2,771,929	6,203	$446.87	15.9
Powder River	97	797,988	2,050	$389.26	4.7
Powell	712	2,396,941	6,785	$353.27	10.5
Prairie	88	579,448	1,297	$446.76	6.8
Ravalli	3,247	11,580,006	27,447	$421.90	11.8
Richland	1,077	3,808,468	10,510	$362.37	10.2
Roosevelt	3,567	8,055,044	10,864	$741 44	32.8
Rosebud	1,830	4,066,316	10,592	$383.90	17.3
Sanders	1,465	4,219,345	8,844	$477.09	16.6
Sheridan	258	1,411,847	4,490	$314.44	5.7
Silver Bow	5,474	18,945,972	34,128	$555.14	16
Stillwater	506	2,396,633	6,735	$355.85	7.5
Sweet Grass	255	983,158	3,120	$315.11	8 1
Teton	490	2,007,992	6,190	$324.39	7.9
Toole	533	1,920,646	4,983	$385 44	10.7
Treasure	55	95,927	884	$108.51	6.2
Valley	1,215	3,678,712	8,195	$448.90	14 8
Wheatland	246	1,333,078	2,264	$588.82	10.8
Wibaux	134	725,357	1,129	$642.48	11.9
Yellowstone	13,367	44,227,822	118,063	$374.61	11.3

Medicaid Program

Medicaid Clients by County

Medicaid Expenditures by County



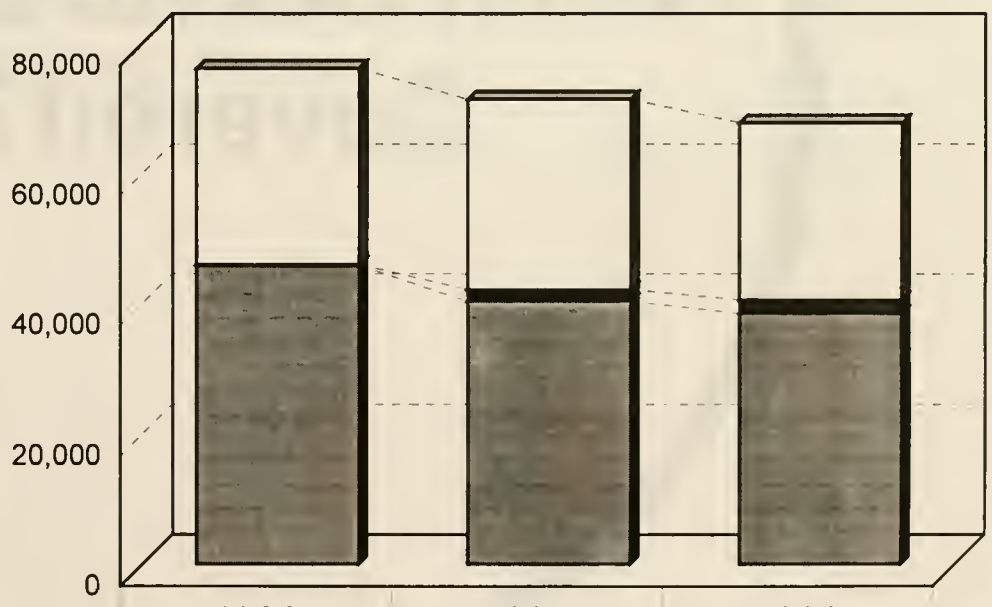
Medicaid Program

Medicaid managed care in Montana is made up of 2 major components: Passport and HMO program. Under the Passport program, eligible Medicaid enrollees choose a primary care provider (PCP) who then manages their health care. Many services not provided by the PCP require the PCP's authorization to be reimbursed under the program. The care management provided by the PCP enhances care while reducing costs by minimizing ineffective or inappropriate medical care to Medicaid recipients. Approximately 43,000 Medicaid recipients in 52 counties are on the Passport program.

Under the HMO program, the state pays a monthly capitation rate for each HMO enrollee. The HMO is then fully responsible for provision of those services covered under the contract. These include hospital services and most primary care services. There are approximately 2,100 people enrolled in Medicaid HMO's as July 1998.

Managed Care Recipients and Total Eligibles

1996 - 1998

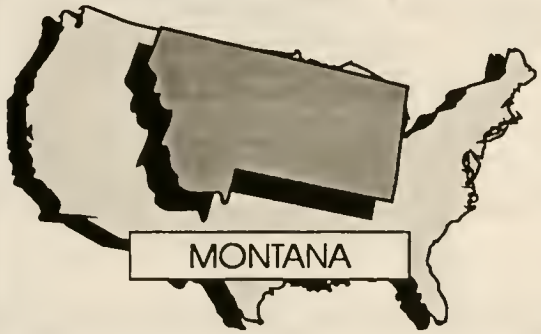


	1996	1997	1998
Fee for Service	30,154	29,313	27,241
HMO	150	1,802	2,101
Passport	45,881	40,336	38,474

Monthly Snapshot as of May of Each Year.

Medicaid Program

What Services are Covered?



Medicaid Program

Montana Medicaid covers a comprehensive set of medical services.

Federal Medicaid law requires certain basic services to be offered to categorically needy clients. These services include but are not limited to, inpatient and outpatient hospital services, physicians services, lab and x-ray, nursing facility services, family planning, home health, and nurse mid-wife services.

States may elect to cover other optional services. In Montana, the legislature has chosen to cover a number of cost effective optional services including outpatient drugs, durable medical equipment, dental services, and physical, occupational, and speech therapy. (The Montana Medicaid service package is detailed on page 23)

Montana Medicaid Covered Services

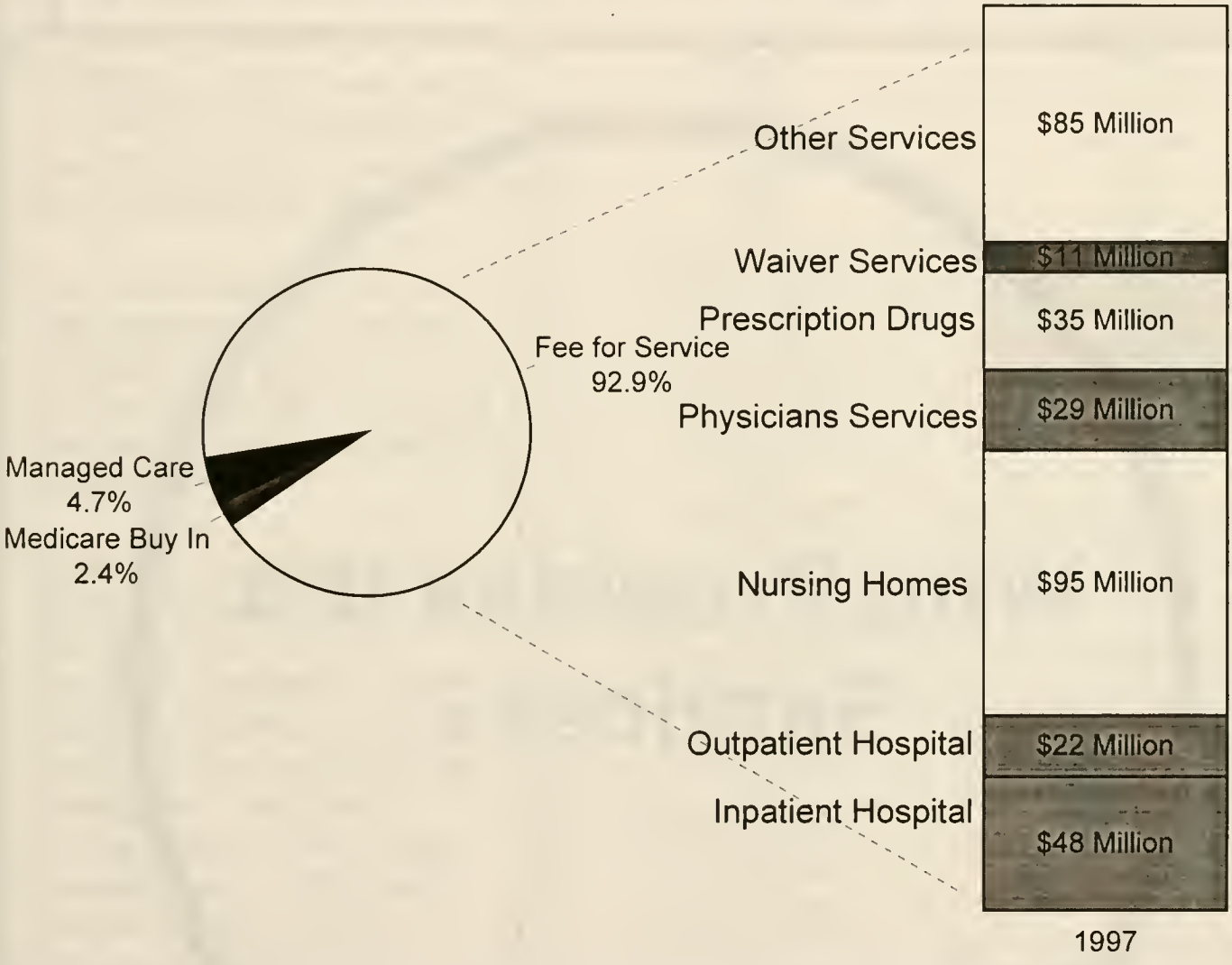
Service	Categoncally Needy - Children	Categorically Needy - Adults	Medically Needy	Faim Adults
Ambulance	Yes	Yes	Yes	Yes
Anesthesia	Yes	Yes	Yes	Yes
Audiology	Yes	Yes	Yes	Yes
Targeted Case Management	Yes - Limited	Yes - Limited	Yes - Limited	Yes - Limited
Chemical Dependency	Yes	No	Children Only	No
Chiropractic	Yes	QMB Only	QMB Only	No
Clinic Services	Yes	Yes	Yes	Yes
Community Mental Health Centers	Yes	Yes	Yes	Yes
Dental Services	Yes	Yes	Yes	No
Dentures	Yes	Yes	Yes	No
Prescnption Drugs	Yes	Yes	Yes	Yes
Dialysis	Yes	Yes	Yes	No
Durable Medical Equipment	Yes	Yes	Yes	No
Emergency Rooms	Yes	Yes	Yes	Yes
Eyeglasses	Yes	Yes	Yes	No
Family Planning	Yes	Yes	Yes	Yes
Federally Qualified Health Centers	Yes	Yes	Yes	Yes
EPSDT	Yes	No	Children Only	No
Hearing Aids	Yes	Yes	Yes	Yes
Home Health	Yes	Yes	Yes	Yes
Hospice	Yes	Yes	Yes	Yes
Inpatient Hospital Care	Yes	Yes	Yes	Yes
Nursing Facility Services	Yes	Yes	Yes	Yes
Nursing	Yes	Yes	Yes	Yes
Nutrition Therapy	Yes	Yes	Yes	No
Occupational Therapy	Yes	Yes	Yes	Yes
Optometnc	Yes	Yes	Yes	No
Organ Transplant	Yes	Limited	Limited	Limited
Out of State Medical Services	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
Outpatient Hospital Care	Yes	Yes	Yes	Yes
Respiratory Services	Yes	No	Children only	No
Pain Management	Yes	Yes	Yes	Yes
Personal Care	Yes	Yes	Yes	No
Physical Therapy	Yes	Yes	Yes	Yes
Physician Services	Yes	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes	Yes
Private Duty Nursing	Yes	Yes	Yes	No
Psychiatric Services	Yes	Yes	Yes	Yes
Residential Psychiatric	Yes	No	Children only	No
Rural Health Clinics	Yes	Yes	Yes	Yes
School Medical Services	Yes	No	Children only	No
Speech Therapy	Yes	Yes	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
X-ray and Lab Services	Yes	Yes	Yes	Yes

P/A: prior Authorization Required

Medically needy: A variable spenddown per Client is required.

Organ transplants; Coverage for adults is limited kidney, cornea, and Bone Marrow.

Medicaid Program



This chart reflects the total breakdown of expenditures for Medicaid by payment type on the left and a breakdown of fee for service payments on the right. It should be noted that mental health managed care started on April 1, 1997 and only three months of expenses in that type of managed care are included in 1997. Costs increased for mental health managed care to nearly $50 million in 1998. In addition, the PASSPORT program is paid on a fee for service basis even though it is a form of managed care.

Medicaid Program

Who Provides the Services?

Medicaid Program

As of May of 1997, services to our clients were provided by over 8,000 active providers and 4 participating HMO's.

The vast majority of services are reimbursed on a "fee for service" basis with the remainder paid for by an HMO and reimbursed to the HMO on a capitated basis.

The department fiscal agent for the Medicaid program is Consultec Inc. In 1997, Consultec processed 3,385,951 claims. Claims are paid every two weeks with an average of 7 days from claims receipt to processing. Approximately, 70% of all claims are submitted and processed electronically.

Type of Service	Number of Providers
Physician	3055
Dentist	464
Pharmacist	399
Hospital	534
EPSDT	159
Podiatry	43
Physical Therapy	221
Speech Therapy	131
Audiology	39
Hearing Aids	46
Occupational Therapy	115
Home Health	68
Personal Care	45
Dialysis	17
Private Nursing	34
Clinics	50
Psychological Services	168
Durable Medical Equipment	451
Optometric/Optician	242
Transportation	57
Ambulance	159
Nursing Homes	115
HCBS	440
Case Management	46
Rehabilitation	31
Nutrition	24
Inpatient Psychiatric	14
ICF-MR	3
Laboratory & X-ray	77
Social Worker	521
Denturist	6
Mid-Level Practitioners	307
Chiropractor	68
Hospice	15
RHC	27
FQHC	13
HMO	4
Total (5/31/97)	8247

Medicaid Program

How do we set payment rates for services?

Rate Setting: The Medicaid Program uses several methods to establish payment rates for services.

Fee for Service: The Department reimburses most providers on a fee for service basis. Rates are established based on costs or a percentage of charges in accordance with federal regulations. In general, rates are prospective in nature and payment is final with no settlement back to actual costs.

Capitation Payments: For HMO's and Mental Health Managed Care the program utilizes a fully capitated risk based reimbursement system. For example, an HMO is paid a pre-determined capitation rate each month and assumes full responsibility for payment for client services for that month.

Special Fee for Service systems used by the Medicaid Program include a Diagnosis Related Groups (DRG) system for inpatient hospitals, ambulatory procedure groups for certain outpatient hospital services, and the resource based relative value system for physician and certain mid-level practitioners. These reimbursement systems use cost, utilization, and other factors in determining provider payment rates.

Medicaid Program

What is the source of our funding and how is it spent?

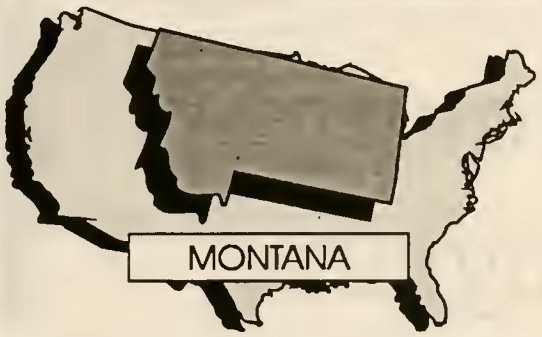
Medicaid services are funded with state general funds and matching federal funds. The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita personal income compared to the national average.

MEDICAID BENEFITS		
MONTANA	1997	1998
Federal Match Rate	69.1%	70.17%

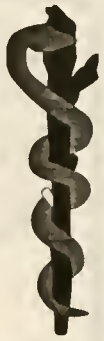
The matching rate for Medicaid administration varies from 50% to 90%.

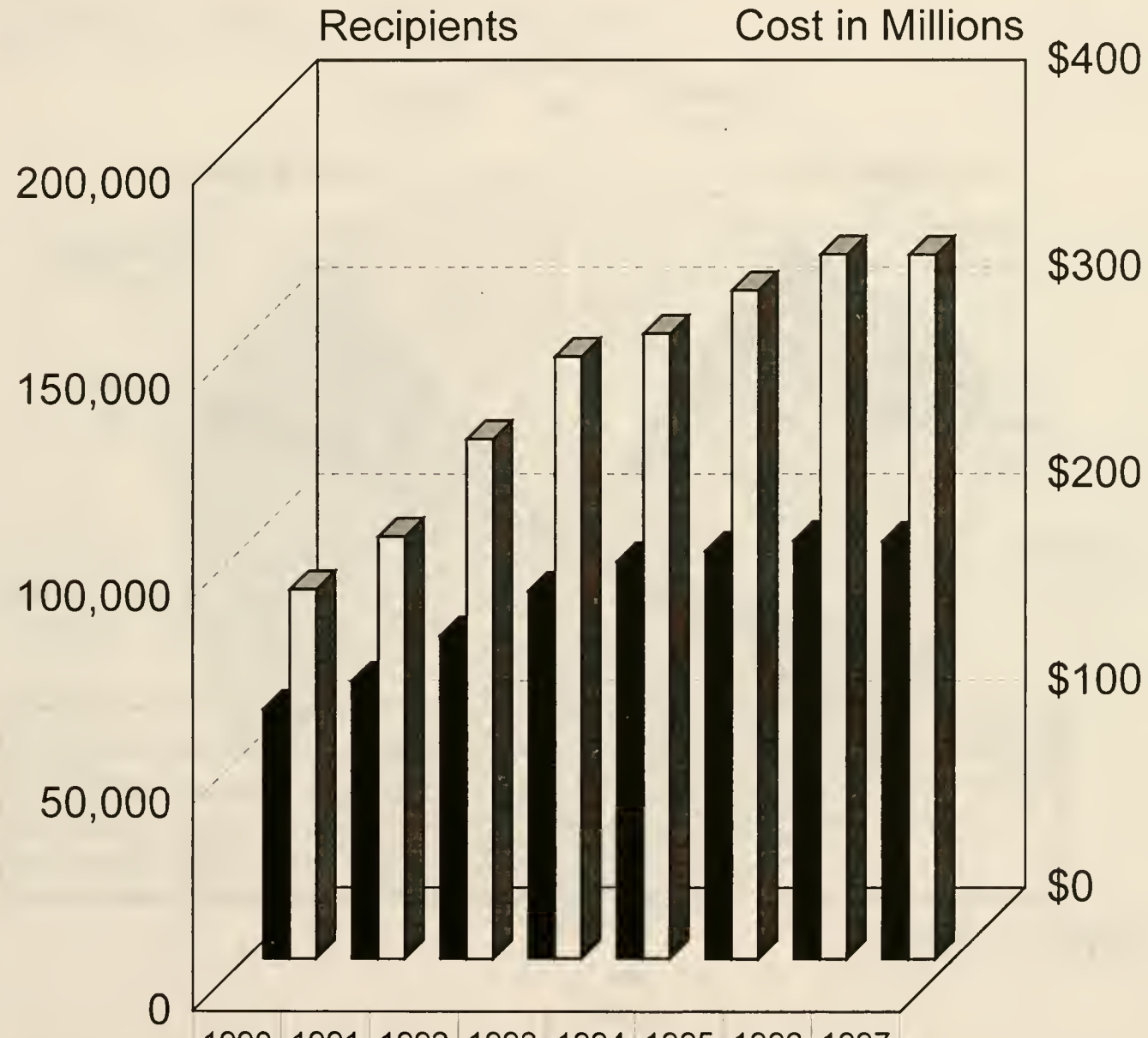
Medicaid Program

Cost Analysis



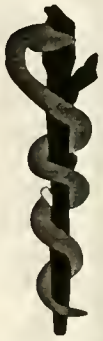
Medicaid Program

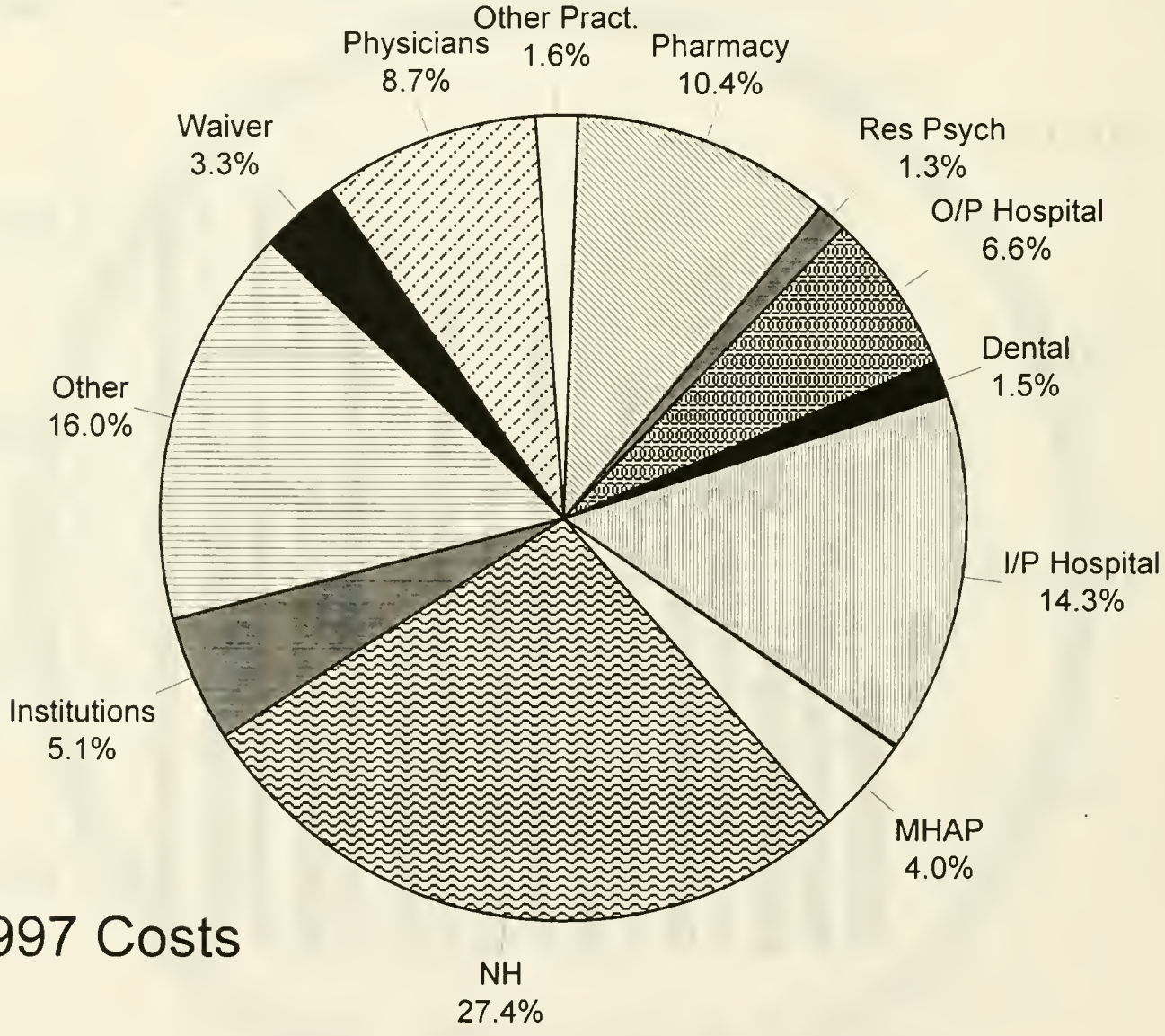




	1990	1991	1992	1993	1994	1995	1996	1997
Recipients	60,367	67,166	78,211	89,041	96,206	98,708	101,271	101,100
Cost in Millions	$179	$204	$251	$291	$302	$323	$341	$340

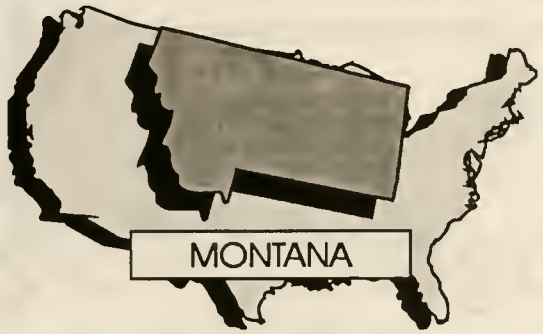
Medicaid Program





1997 Costs

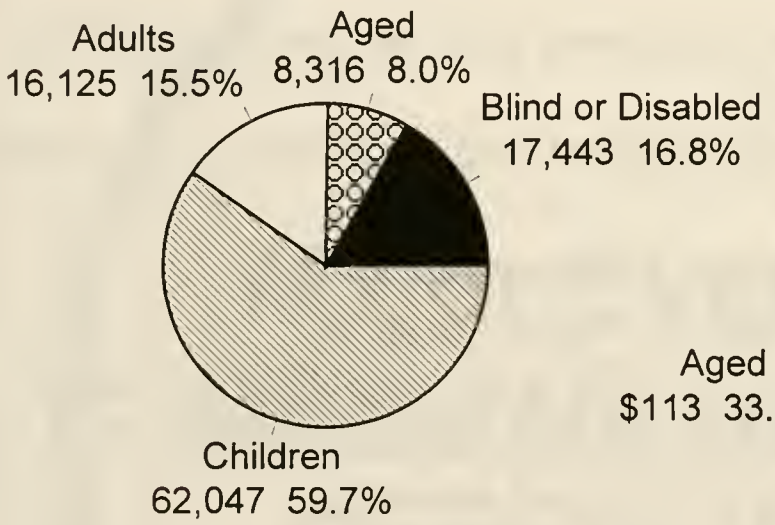
Medicaid expenses included in this analysis exclude Indian Health, and Medicare Buy-In. Total expenses are approximately $340.5 Million for Fy 1997.



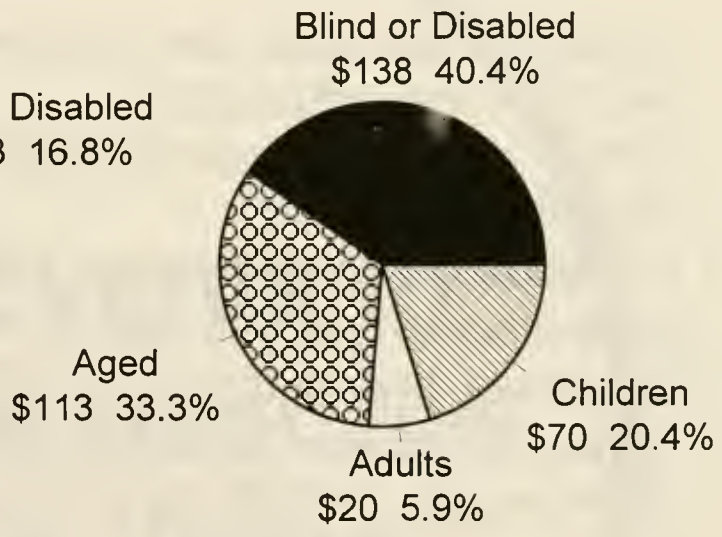
Medicaid Program

Cost by Major Aid Category

Recipients



Cost in Millions

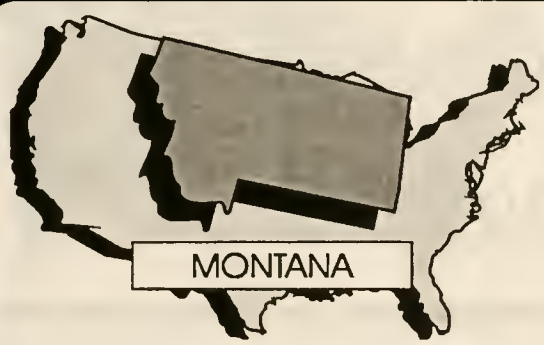


This chart reflects funds expended by aid category in 1997. It should be noted that the aged and disabled are a relatively small percentage of the entire population, but utilize a very high percentage of the total funds expended in Medicaid.

Medicaid Program

In 1997 the Medicaid Program continued develop cost containment measures that would enhance the cost effectiveness and efficiency of the program.

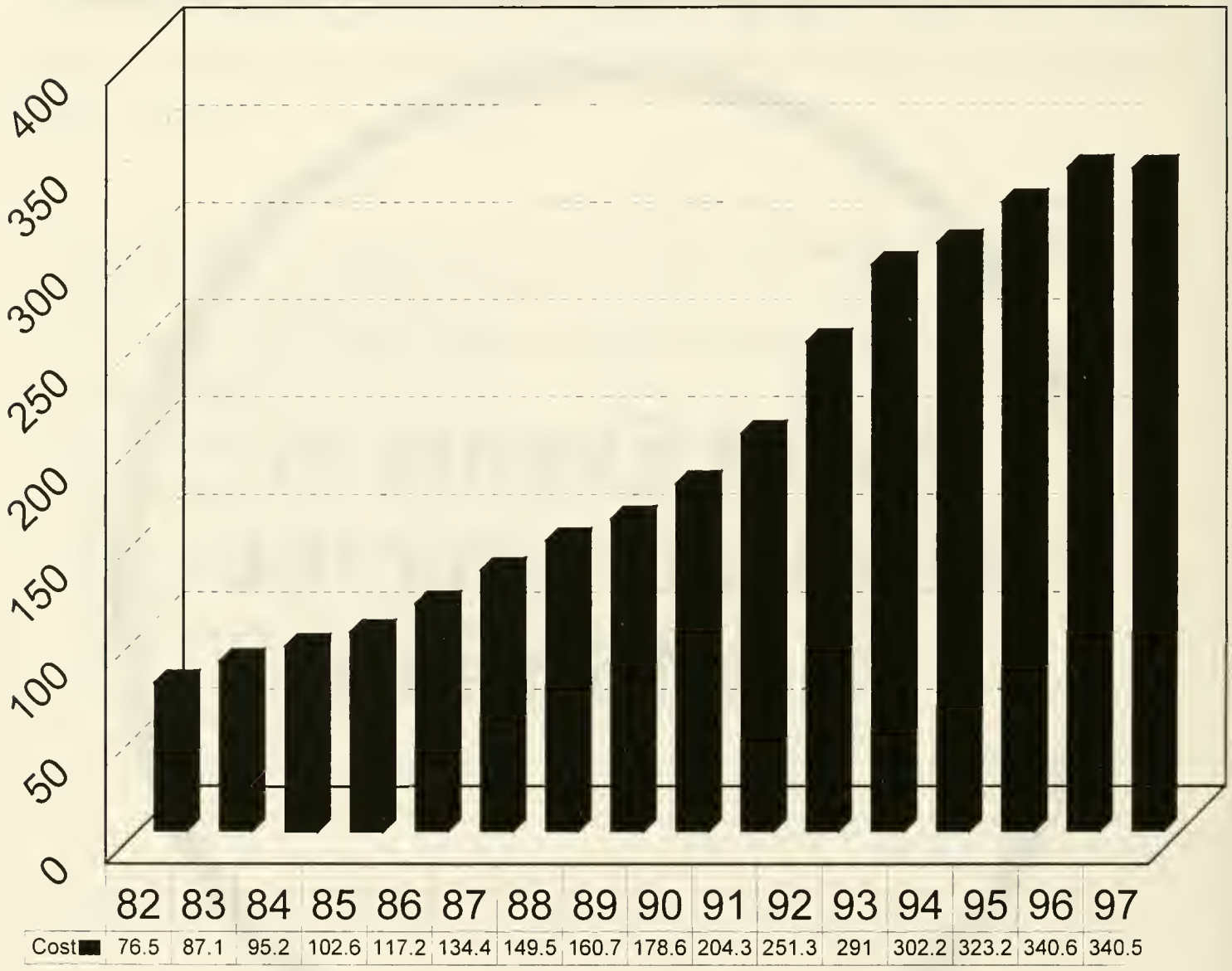
- ✓ Expanded managed care programs such as Medicaid HMO's and the Passport program.
- ✓ Enhanced the drug rebate program and improved drug rebate collections
- ✓ Developed and implemented a new prospective reimbursement for outpatient hospital services.
- ✓ Enhanced prior authorization efforts in the SURS unit has saved the Medicaid system $466,437 through denials of unnecessary medical equipment and services.



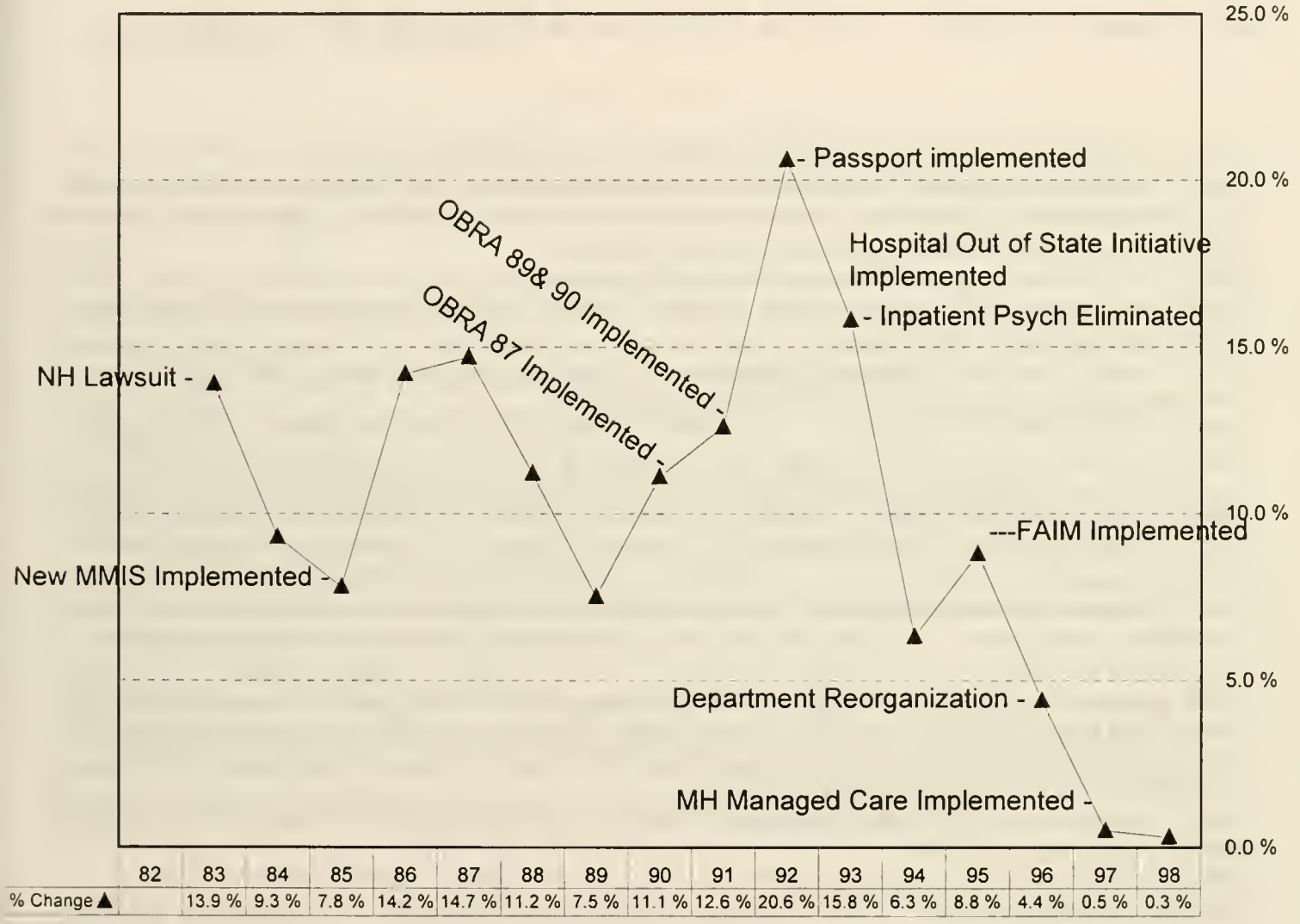
Medicaid Program

Major Events in Medicaid over the Past 15 Years

Medicaid Program



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97
Cost	76.5	87.1	95.2	102.6	117.2	134.4	149.5	160.7	178.6	204.3	251.3	291	302.2	323.2	340.6	340.5



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98
% Change ▲		13.9 %	9.3 %	7.8 %	14.2 %	14.7 %	11.2 %	7.5 %	11.1 %	12.6 %	20.6 %	15.8 %	6.3 %	8.8 %	4.4 %	0.5 %	0.3 %

Medicaid Program

Chronology of Major Events in Montana Medicaid Since 1982.

- 1982 - Prospective reimbursement system instituted for the Nursing Home program.
- 1983 - Department loses Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1. retroactive payments made for past years. 2. Increased reimbursement rates in subsequent rates.
- 1985 - New MMIS instituted with Consultec as the fiscal agent.
- 1987 - New Hospital reimbursement system instituted. This is Diagnosis Related Group (DRG) system which is a prospective rate system.
- 1988 - Inpatient Psychiatric Services for Children under age 21 was implemented as a Medicaid Service. This service increased costs rapidly for the next several years.
- 1990 - Federal OBRA 87 implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate primarily affected the nursing home industry, and accordingly increased Medicaid costs through increased reimbursement to providers. OBRA 87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children under age 6.
- 1991 - Nursing home provider tax implemented. This change allowed for increased reimbursement to nursing homes utilizing a state tax on nursing homes matched with federal Medicaid dollars.
- 1992 - Implemented Federal OBRA 89. Increased eligibility for pregnant women and children to 133% of the federal poverty index. Language stipulated that children are eligible for all medically necessary services.
- 1992 - Implemented Federal OBRA 90 - A major component of this mandate was to increase eligibility for children age 6 to 18 to 100% of the federal poverty index. This mandate is being phased in through 2002.
- 1992 - Implemented Residential Psychiatric Services as a Medicaid Service. This service saw rapid increases in cost over the next several years.
- 1992 - Implement the Drug Rebate Program which returns a significant portion of prescription drug costs to the state in the form of rebates.
- 1993 - Passport to Health program implemented. The program assigns certain providers to each participating Medicaid eligible to act as a manager or gatekeeper of services. The program has resulted in significant savings in subsequent years.
- 1993 - Implemented new hospital reimbursement system. System features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change resulted in significant savings in subsequent years.
- 1993 - Implemented the out of state hospital initiative. This program restricted the use of higher cost out of state hospitals when in state hospitals provided the same services. This initiative has resulted in significant savings in subsequent years.

Medicaid Program

Chronology -Continued

- 1994 - Inpatient psychiatric services terminated by the legislature as a Medicaid service.
- 1994 - Formulary and Drug Utilization Review Program implemented for Medicaid pharmacy services. This program provided significant internal controls and cost savings in subsequent years.
- 1995 - Liens and Estates Recovery Program implemented by the legislature.
- 1995 - The Families Achieving Independence in Montana (FAIM) program was implemented. FAIM resulted in many Montanans leaving welfare rolls subsequently reducing the number of Medicaid eligibles resulting in significant savings in the Medicaid program.
- 1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMO's exist.
- 1996 - Departmental reorganization is implemented. Reorganization resulted in a decentralization of Medicaid by which services are managed in divisions primarily responsible for services to specific populations. for example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.
- 1997 - Mental Health Managed Care is implemented. This program institutes a managed care contract for all mental health services statewide.
- 1998 - Child Health Insurance Program (CHIP) state plan is submitted. The state has submitted a state plan requesting funding for implementation of a CHIP program for Montana. This program would provide funding for premiums to purchase insurance for children 18 and under and under 150% of the federal poverty index. Children eligible for Medicaid would remain in that program. Outreach for chip is expected to increase the number of children on Medicaid.

Medicaid Program

Expenditure Projections Fy 2000 & 2001

Medicaid Program

Projection Methodologies

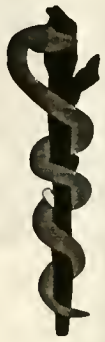
The methodology used by DPHHS to develop Medicaid cost projections is a process that integrates cost projections developed independently in each Medicaid impacted division. The independent estimates are obtained as follows:

Disabilities Services Division: The Disabilities Services Division develops cost projections for developmental disabilities program costs based on the number of group home and other Medicaid service provider contracts planned to be in existence during the new biennium. Costs of these programs are not processed through the DPHHS Medicaid computerized claims processing system (MMIS/Consultec).

Health Policy and Services Division: The Health Policy and Services Division projects Medicaid costs for medical services that are reimbursed through the MMIS as well as for some costs that are not paid through the MMIS. The latter category contains such costs as Medicare Buy-In and Indian Health Service. The great preponderance of costs projected by this Division are paid through MMIS and the projections are based on paid claims history data obtained from the MMIS database. A computerized model that uses recent "date of service" based payments has been developed to yield projections for each category of service in the primary care area. A primary assumption built into the model is that expenditures in the current year will behave in a manner not dissimilar to observed behavior in the last fiscal year. Adjustments are made to take into account lack of historical data and other factors that might drive costs in directions different from what would occur by simply using historical drivers. The estimates thus obtained are used for current year comparisons with the Operations and Technology model results to insure that our base year estimates provide a solid base for the OTD next biennium estimates.

Senior and Long Term Care Division: The projections done by the Long Term Care Division are based on the MMIS paid claims tape historical database and take into account bed day trends that are evident in the various service categories.

Medicaid Program



Historically, projections for the Medicaid portion of SLTC are based on experience of prior years, which has the underlying assumption that providers will continue to bill for services with the same lag between the service and billing date as they have done in the prior year. We verify that this lag remains relatively constant from year to year to insure the integrity of the underlying assumption.

Generally, the model establishes the number of services and the total cost for each service provided (home health, hospice, personal care) for each group (AFDC, SSI) through the given month for the current and prior year. Over several years, we know what percent of payments for a given service have been made through a given month. (For example, we may know that through May, personal services will be 65% of the amount that will be eventually billed by June of the following year.) Monthly meetings are held between program and budget staff to insure that budget staff are well aware of any programmatic changes that are being implemented and what the expected fiscal impact of those changes will be. Manual adjustments are sometimes made to the projection to take into account programmatic changes. Nursing Home projections work in a similar manner.

Over the past year, SLTC has developed an independent source or method to project each of the Medicaid components of the SLTC division. In the case of home health and personal care, we now receive quarterly reports from each provider that report the type and number of services provided during that quarter, whether or not the services have been billed. We have received these reports for 2 years and they are a very accurate and independent source of information that serves to verify the other projection model.

In the case of nursing homes, there is usually very little lag between the provision of services. However, bed days are reported to the division monthly. Included with this information is whether the services provided are private pay, Medicaid or Medicare and the number of available beds. The occupancy is critical in projecting nursing home costs. The overall state occupancy verifies the trends in the regular projection model.

Medicaid Program

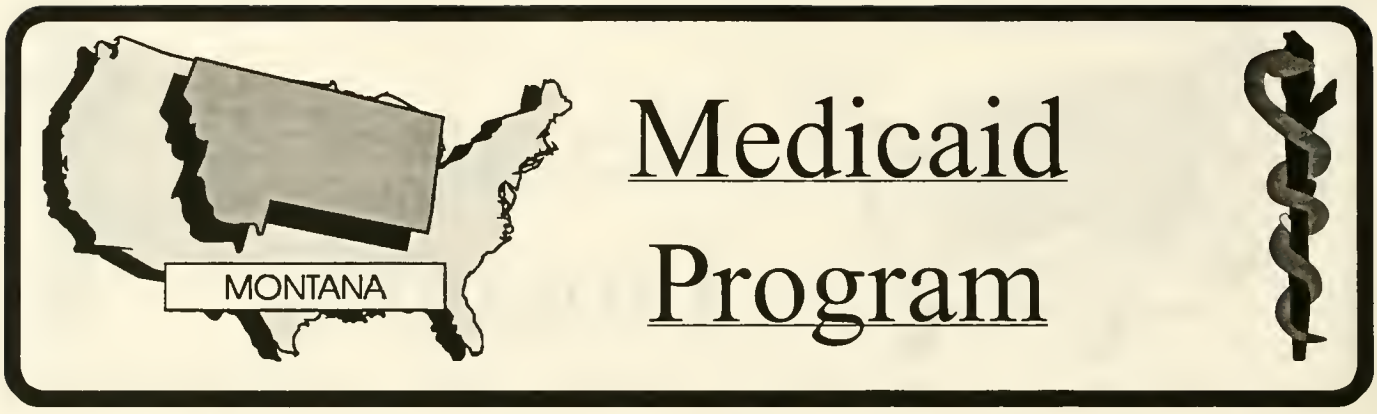
Finally, a recent MedStat analysis has shown that the average age of a nursing home recipient on Medicaid is 82. We have paid a contractor to segregate census data by age in 5 year intervals above age 75. Census projections show 3% growth from 99-00, but show 9% growth between FY 00-01. Not everyone in this age group will enter a nursing home, but there will be a larger pool of persons reaching nursing home age during that interval.

All of these factors are weighed, along with monthly meetings between program and budget staff, and are used to arrive at reasonable and defensible cost projections.

Addictive and Mental Disorders Division: The Addictive and Mental Disorders Division (projections relate exclusively to Medicaid costs arising under the Mental Health Access Plan (MHAP)). The costs in this area are based upon a preset capitation payment made by the state to the MHAP operator for each projected Medicaid eligible person covered by MHAP. Since costs are to replace (and be less than) costs that would have been incurred under pre-MHAP Medicaid coverage, projections in this area must be consistent with historical information on such costs (from MMIS) as well as with known and projected trends of eligible counts for the various categories of MHAP eligible citizens.

Capitation rates are developed using historical cost data which are discounted by 5% from the projected cost if "fee for service" had been continued. Overall program cost projections are related only to estimates of the number of Medicaid recipients by age group and eligibility category (e.g., TANF, AFDC related, SSI, etc.).

Operations and Technology Division: Finally, the Operations and Technology Division has developed a model that provides projections for all Medicaid service categories independent of divisional programs. The OTD model is based on Medicaid expenditure "date of payment" experience, with adjustments made to reflect "date of service" experience. The product of the OTD model is provided to each impacted division for analysis and comparison with the respective

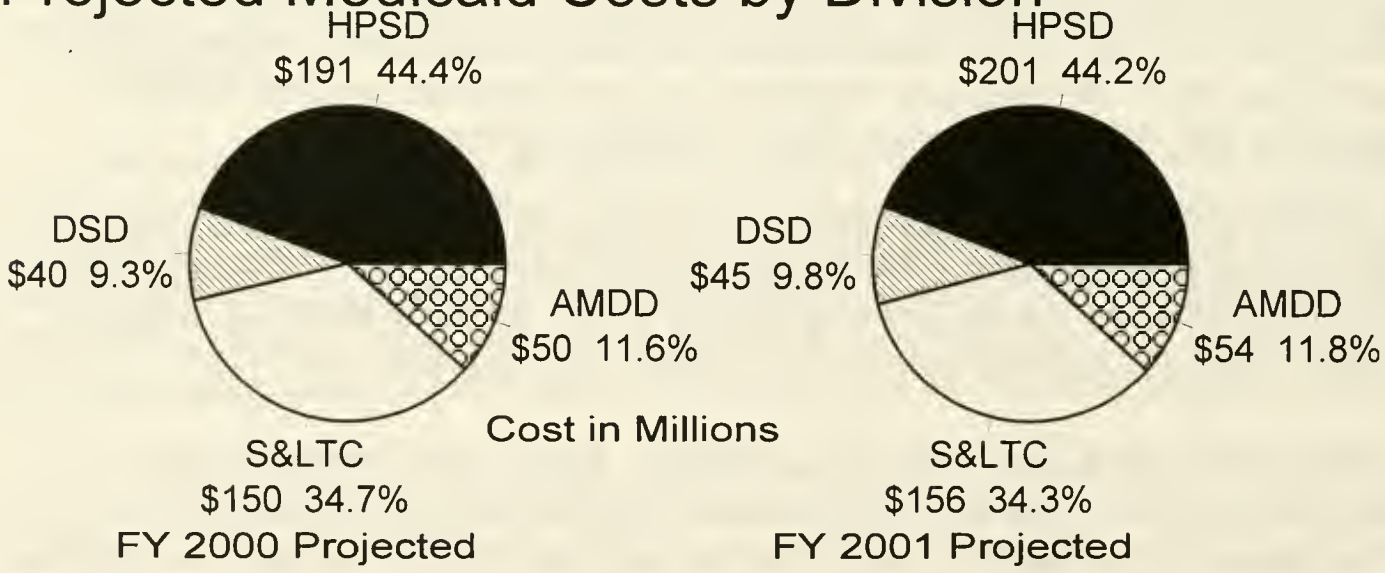


divisional model results. Analysts from the respective divisions meet to reconcile differences in model results and settle on a final set of projections that are then adopted for legislative budget presentation purposes.

It is important to call attention to the fact that no preconceived overall increase percentages are assumed in any of the model building processes. Such percentages can be calculated after the model results have been determined, but they are an output parameter rather than a front-end (input) assumed parameter.

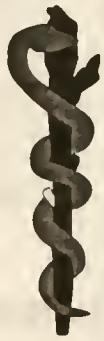
It is also important to reemphasize that when the computerized MMIS data driven models produce results that are inconsistent with "known facts" after future behavior of costs in a specific service category, the history driven outcomes are overridden with cost projections based upon the "known facts".

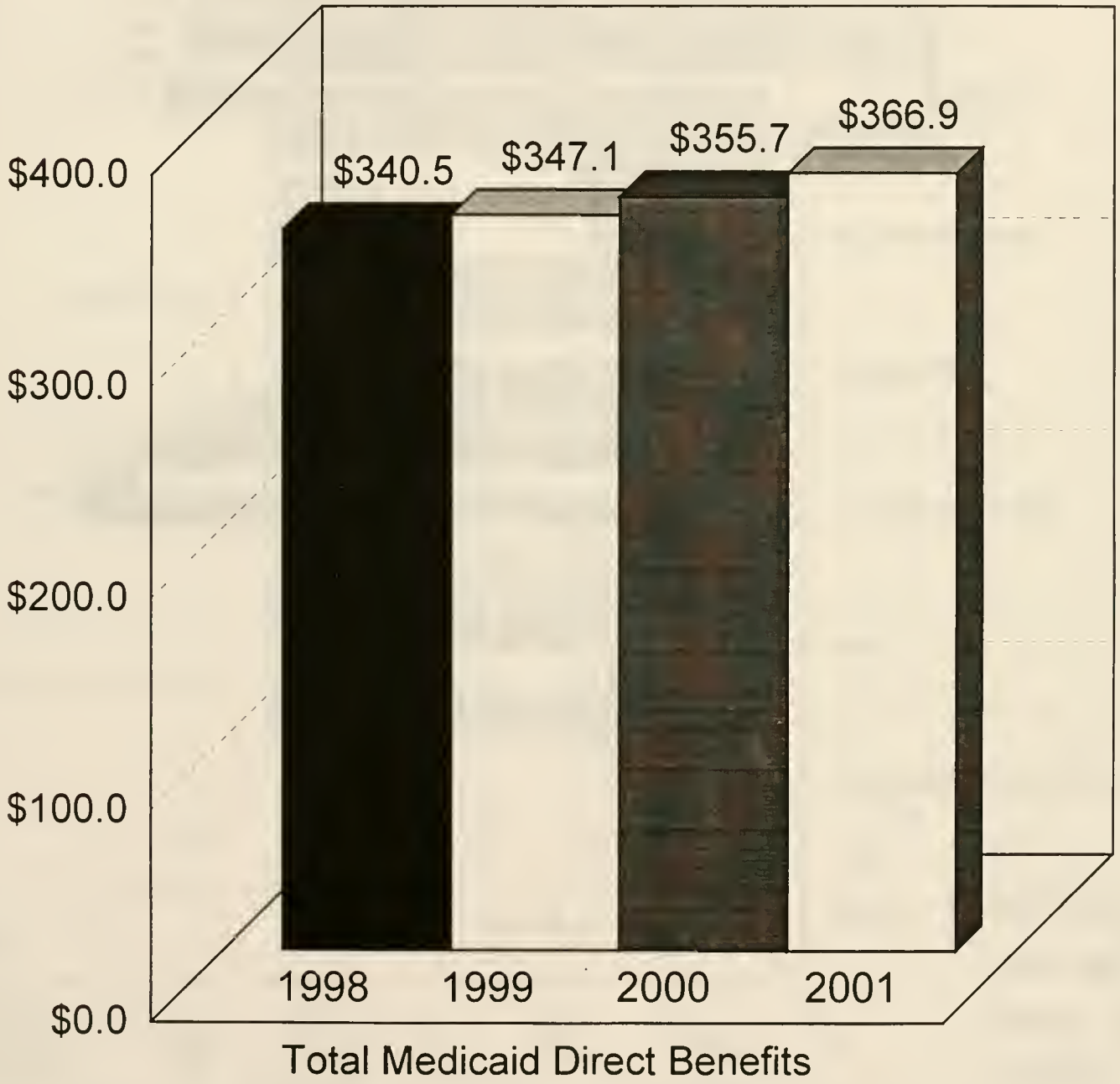
Projected Medicaid Costs by Division



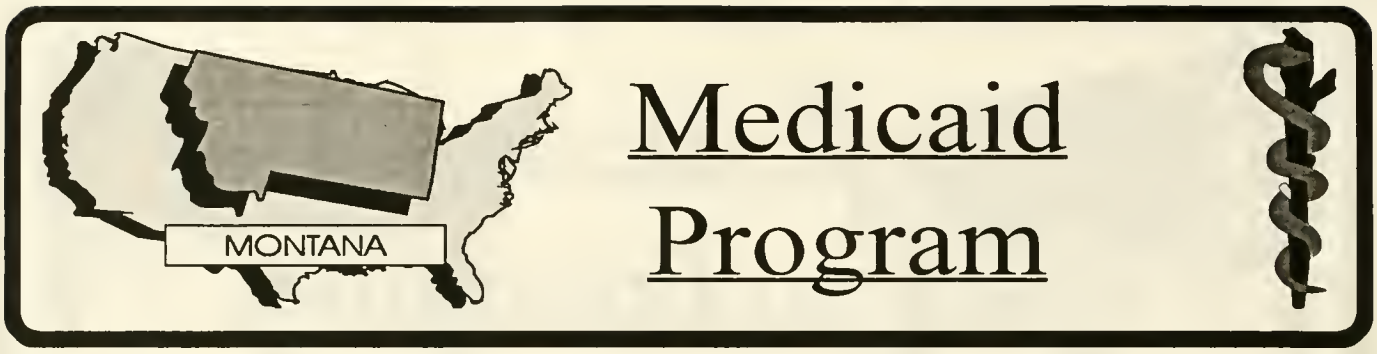
HPSD = Health Policy and Services Division
DSD = Disabilities Services Division
S&LTC = Senior and Long Term Care Division
AMDD = Addictive and Mental Disorders Division

Medicaid Program





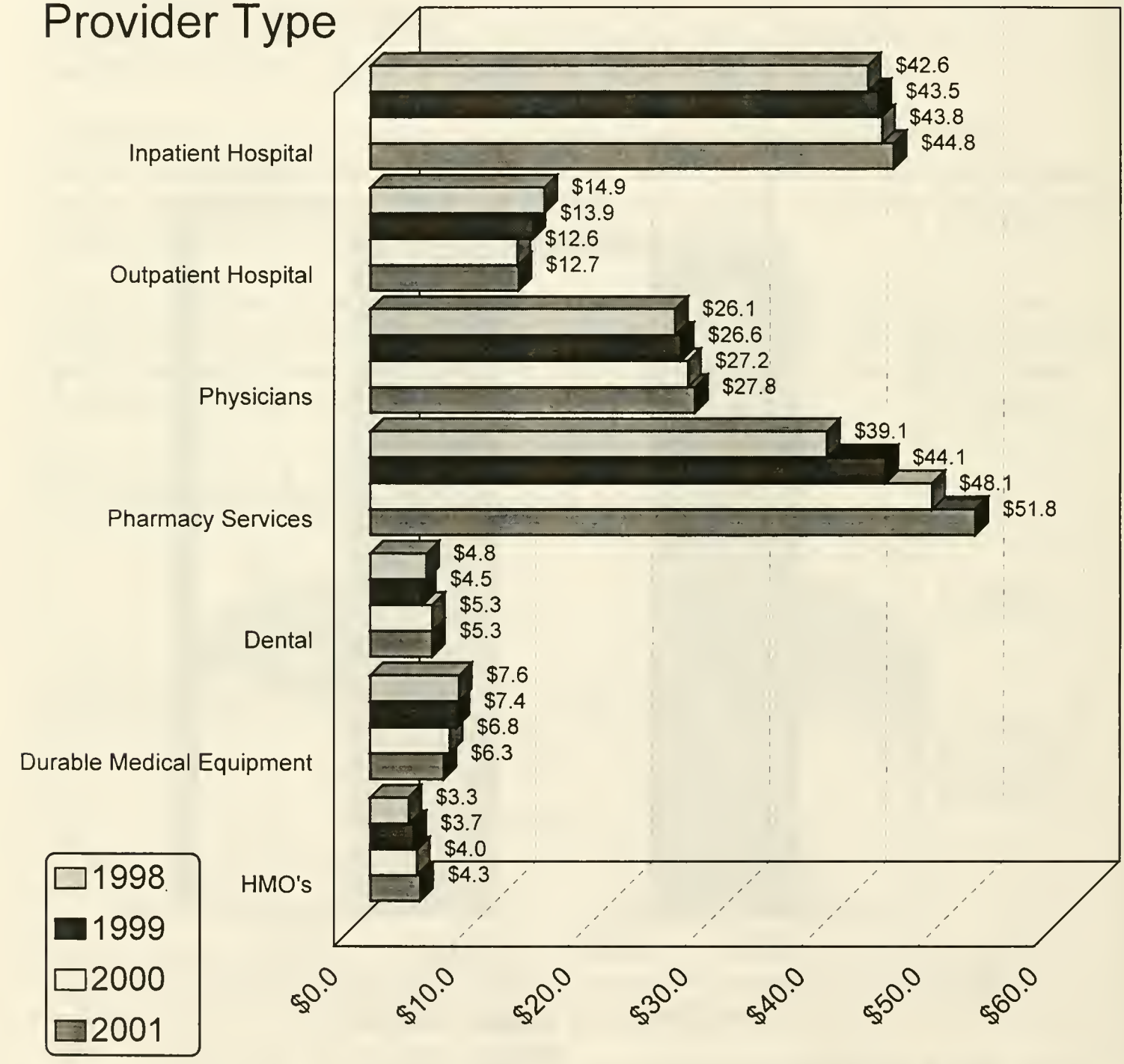
Excludes Indian Health Services, Medicare Buy In and DD Waiver



Medicaid Program

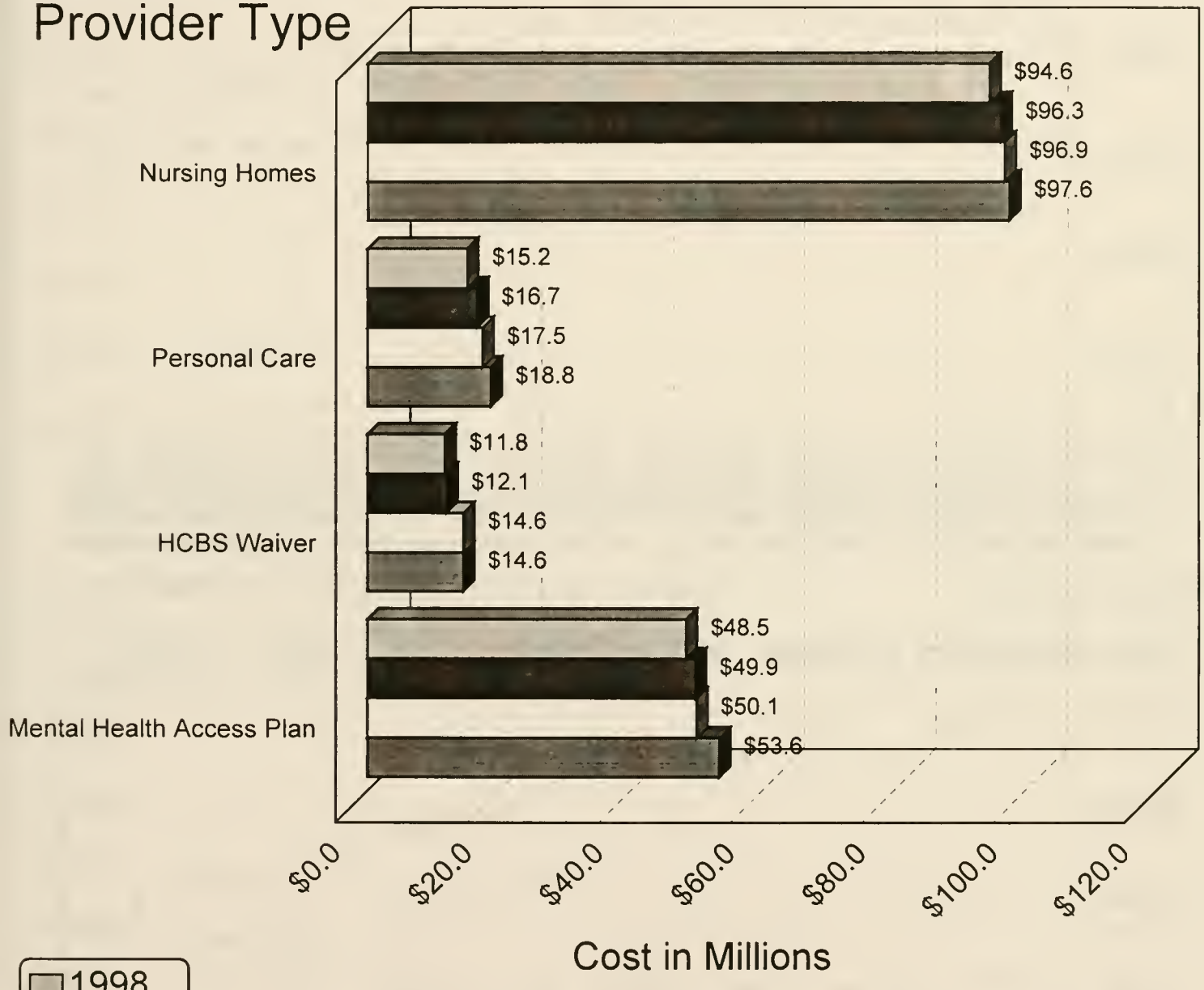
Projections by Provider Type

Cost in Millions



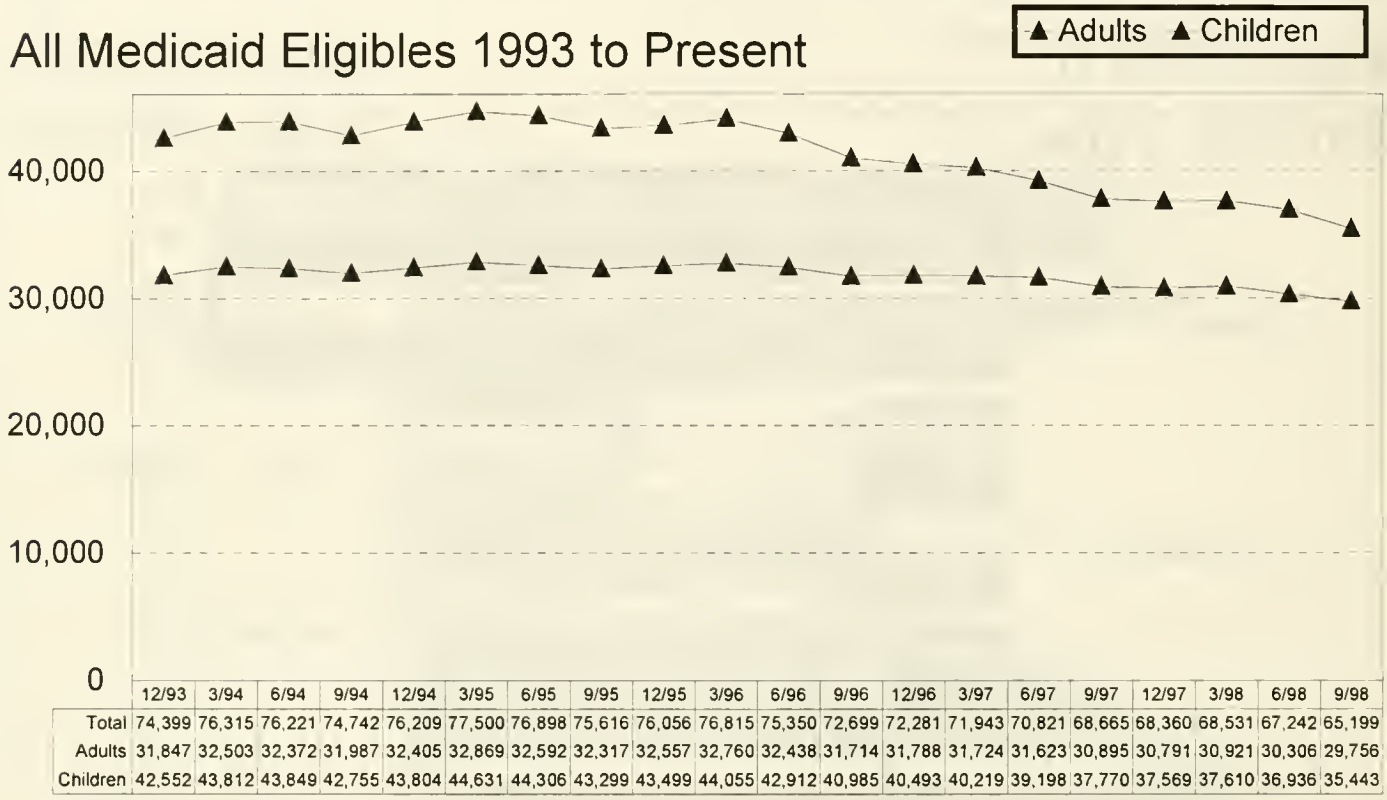
Medicaid Program

Projections by Provider Type



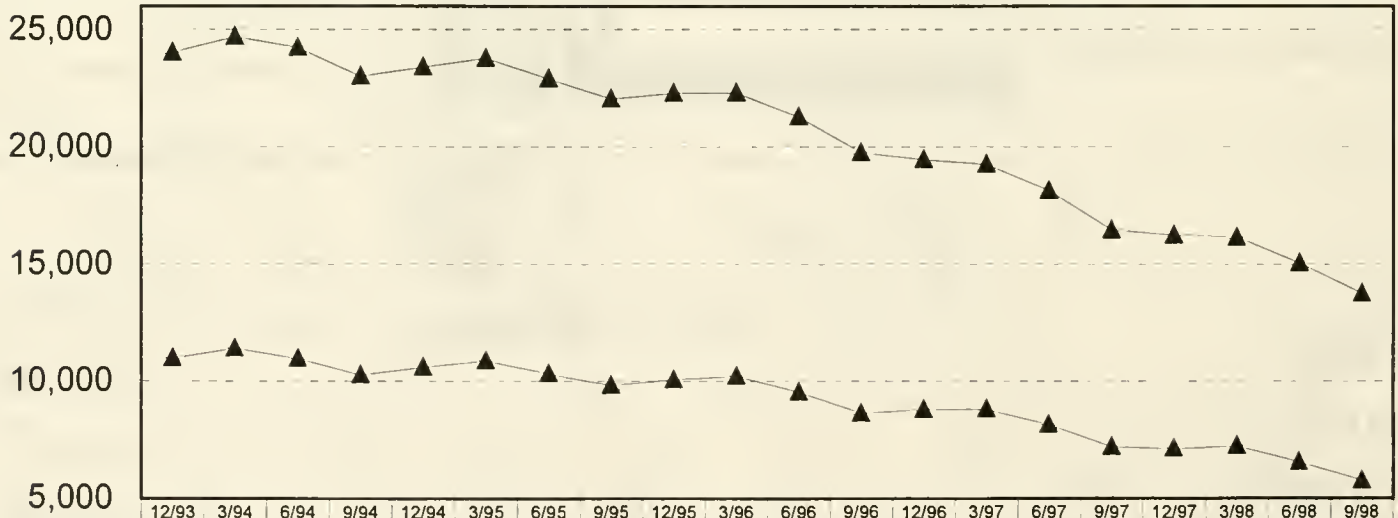
Medicaid Program

All Medicaid Eligibles 1993 to Present

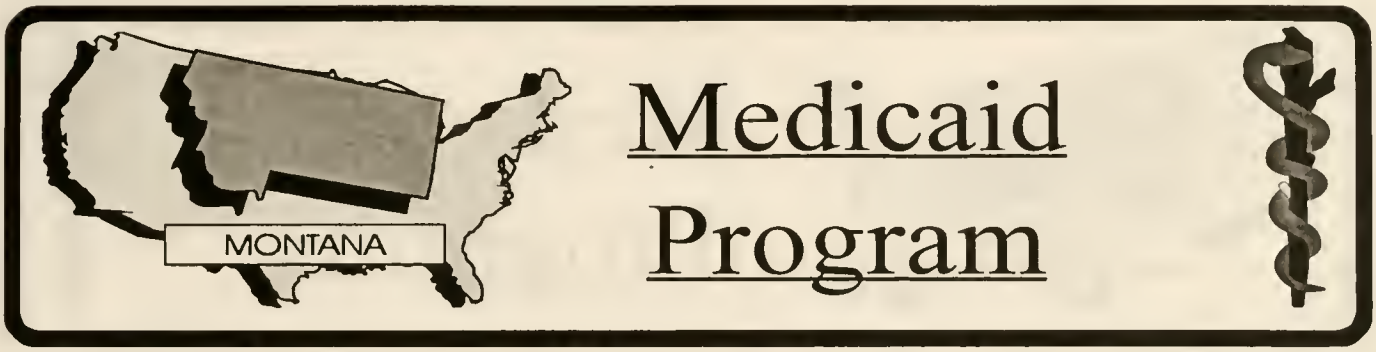


	12/93	3/94	6/94	9/94	12/94	3/95	6/95	9/95	12/95	3/96	6/96	9/96	12/96	3/97	6/97	9/97	12/97	3/98	6/98	9/98
Total	74,399	76,315	76,221	74,742	76,209	77,500	76,898	75,616	76,056	76,815	75,350	72,699	72,281	71,943	70,821	68,665	68,360	68,531	67,242	65,199
Adults	31,847	32,503	32,372	31,987	32,405	32,869	32,592	32,317	32,557	32,760	32,438	31,714	31,788	31,724	31,623	30,895	30,791	30,921	30,306	29,756
Children	42,552	43,812	43,849	42,755	43,804	44,631	44,306	43,299	43,499	44,055	42,912	40,985	40,493	40,219	39,198	37,770	37,569	37,610	36,936	35,443

AFDC/Medicaid Eligibles 1993 to Present

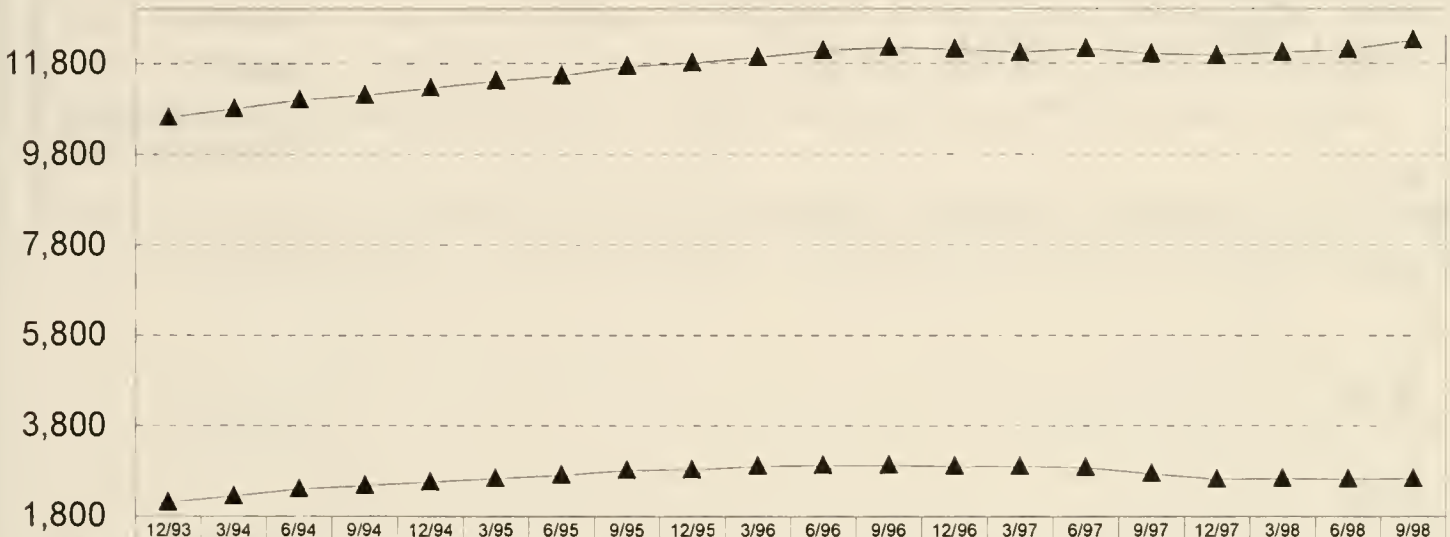


	12/93	3/94	6/94	9/94	12/94	3/95	6/95	9/95	12/95	3/96	6/96	9/96	12/96	3/97	6/97	9/97	12/97	3/98	6/98	9/98
Total	34,967	36,088	35,170	33,263	33,976	34,633	33,202	31,844	32,333	32,495	30,789	28,379	28,237	28,052	26,276	23,657	23,344	23,394	21,590	19,515
Adults	10,956	11,396	10,947	10,256	10,586	10,862	10,306	9,808	10,055	10,201	9,519	8,623	8,776	8,793	8,130	7,196	7,104	7,230	6,542	5,758
Children	24,011	24,692	24,223	23,007	23,390	23,771	22,896	22,036	22,278	22,294	21,270	19,756	19,461	19,259	18,146	16,461	16,240	16,164	15,048	13,757



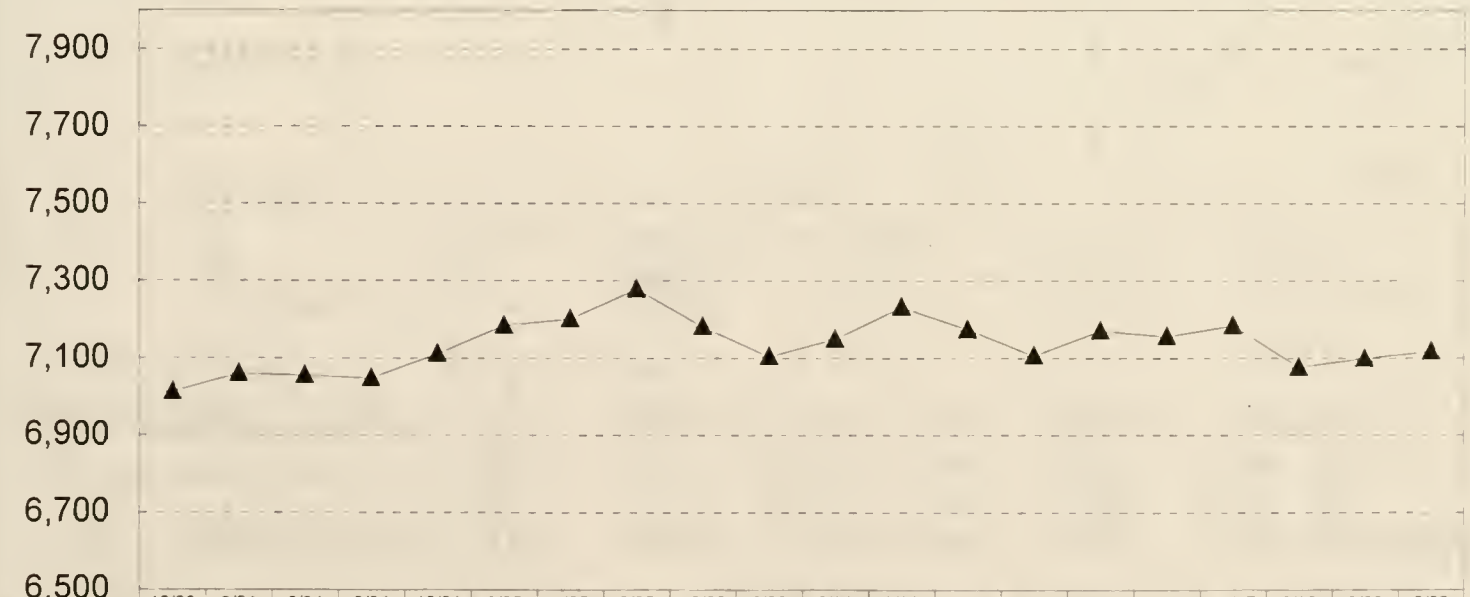
Medicaid Program

Disabled/Medicaid Eligibles 1993 to Present

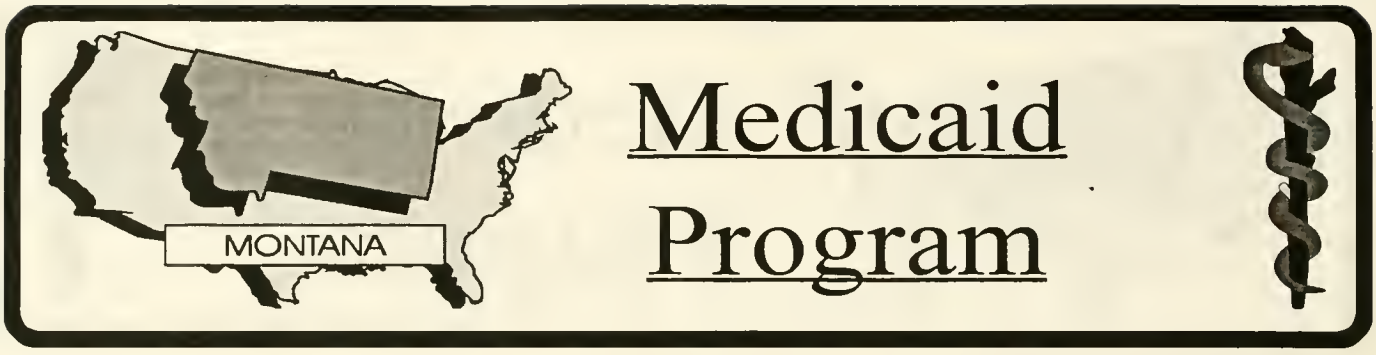


	12/93	3/94	6/94	9/94	12/94	3/95	6/95	9/95	12/95	3/96	6/96	9/96	12/96	3/97	6/97	9/97	12/97	3/98	6/98	9/98
Total	12,712	13,042	13,395	13,568	13,809	14,042	14,223	14,535	14,634	14,823	15,002	15,065	15,007	14,931	14,996	14,742	14,586	14,667	14,717	14,937
Adults	10,611	10,797	10,995	11,094	11,254	11,411	11,520	11,725	11,805	11,922	12,076	12,140	12,103	12,032	12,117	12,003	11,967	12,035	12,097	12,308
Children	2,101	2,245	2,400	2,474	2,555	2,631	2,703	2,810	2,829	2,901	2,926	2,925	2,904	2,899	2,879	2,739	2,619	2,632	2,620	2,629

Aged/Medicaid Eligibles 1993 to Present

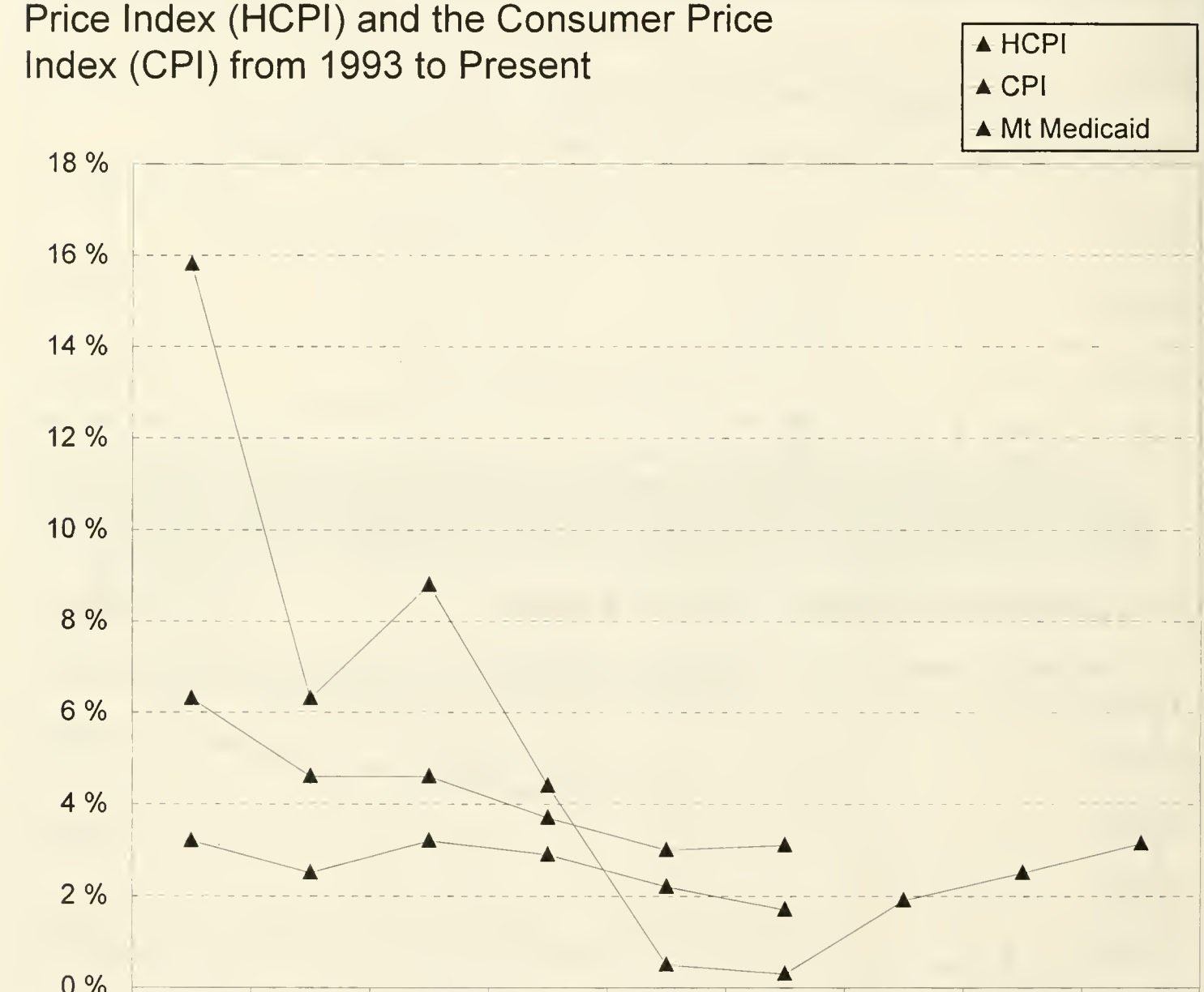


	12/93	3/94	6/94	9/94	12/94	3/95	6/95	9/95	12/95	3/96	6/96	9/96	12/96	3/97	6/97	9/97	12/97	3/98	6/98	9/98
AGED 65 & UP	7,012	7,060	7,055	7,048	7,111	7,184	7,200	7,278	7,181	7,104	7,149	7,231	7,174	7,106	7,170	7,155	7,184	7,076	7,099	7,117



Medicaid Program

Medicaid growth compared to the Health Care Price Index (HCPI) and the Consumer Price Index (CPI) from 1993 to Present

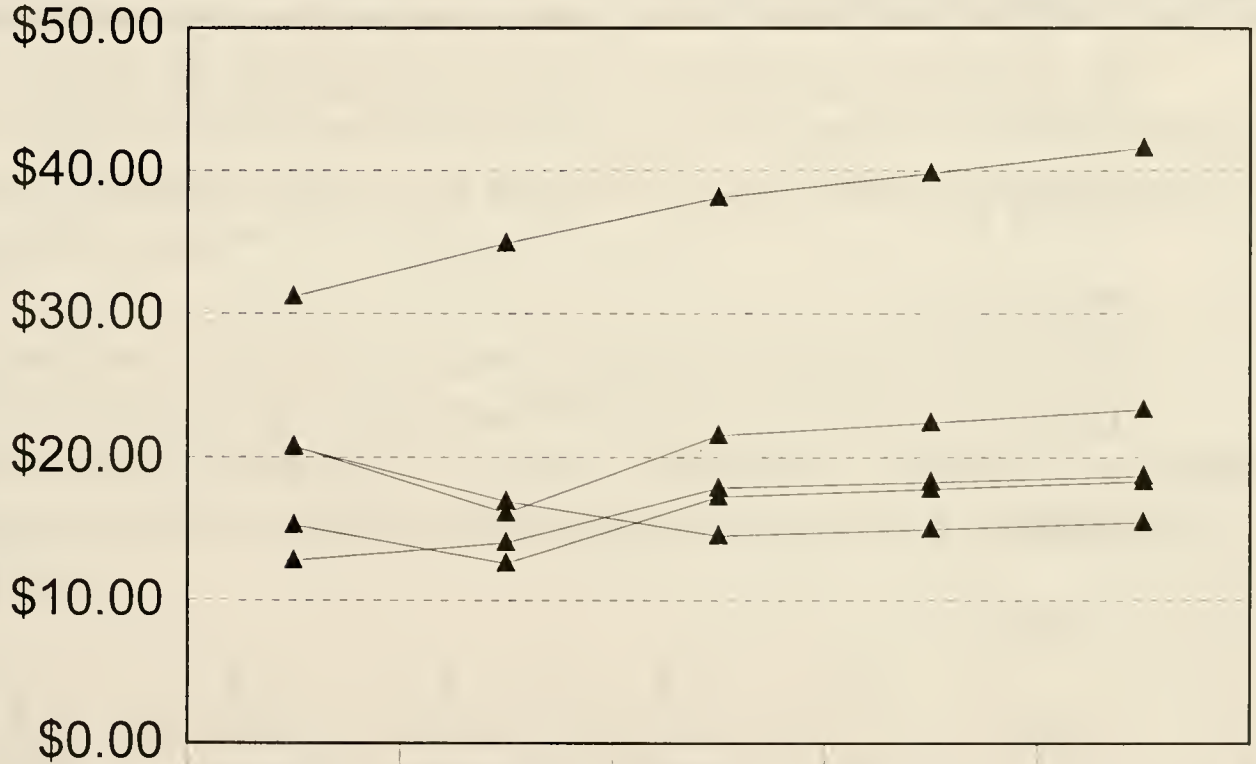


	6/93	6/94	6/95	6/96	6/97	6/98	1999	2000	2001
HCPI	6.3 %	4.6 %	4.6 %	3.7 %	3 %	3.1 %			
CPI	3.2 %	2.5 %	3.2 %	2.9 %	2.2 %	1.7 %			
Mt Medicaid	15.8 %	6.3 %	8.8 %	4.4 %	0.5 %	0.3 %	1.9 %	2.5 %	3.14 %

Medicaid is projected for 1999 through 2001.

Medicaid Program

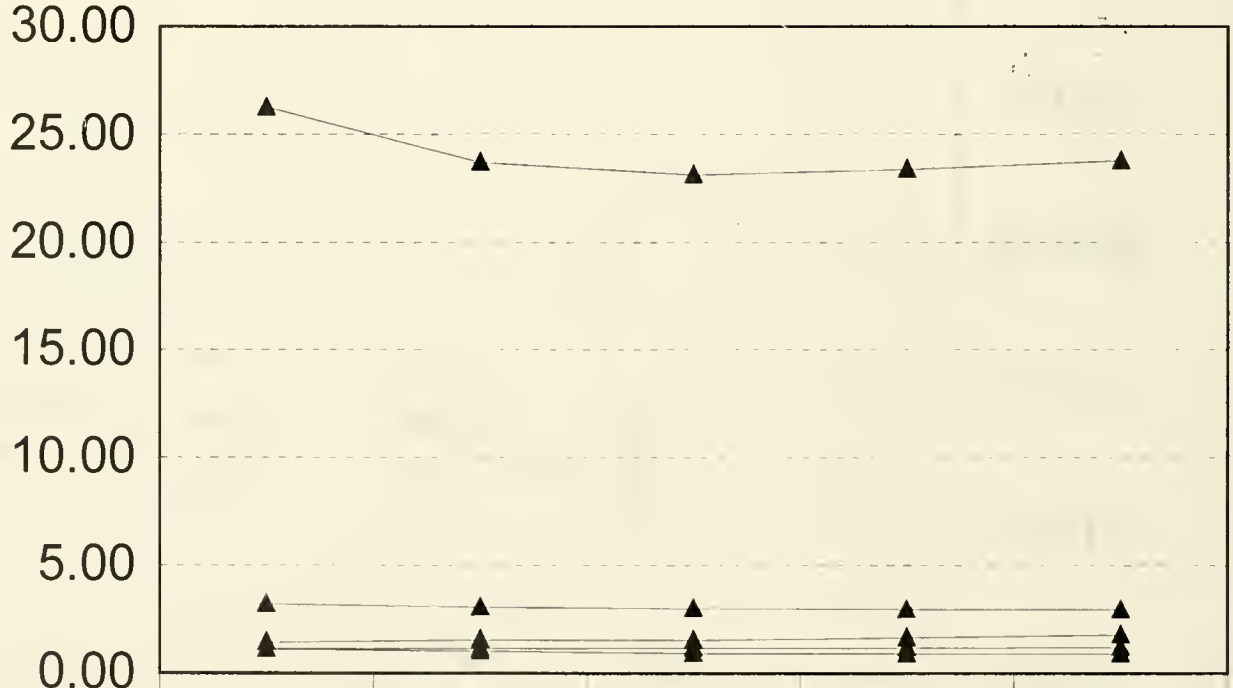
Cost Per Service: Regardless of the provider type the cost of service is an average of the various services rendered by the provider. Each year the average cost per service is strongly affected by a number of factors including patient acuity, new procedures, supply cost, new technology and inflation. Trends in average cost per service was affected by the implementation of the Mental Health Access Plan in 1997.



	1997	1998	1999	2000	2001
Total ▲	$12.77	$14.02	$17.86	$18.27	$18.69
Inpatient Hosp ▲	$15.25	$12.57	$17.24	$17.77	$18.33
Outpatient Hosp ▲	$20.76	$16.10	$21.50	$22.38	$23.30
Physicians ▲	$20.69	$16.92	$14.51	$14.97	$15.45
Drugs ▲	$31.17	$34.88	$38.09	$39.80	$41.60

Medicaid Program

Units of Service: The definition of a unit of service varies greatly both within and between provider types. Medicaid covers approximately 10,000 procedures. These procedures can vary from extreme complexity to as simple as administering a Band-Aid on a minor wound. The total of units of service is affected each year by a number of factors including patient acuity, technology changes, changes in treatment protocol. Trends in units of service were affected by the implementation of the Mental Health Access Plan in 1997.



	1997	1998	1999	2000	2001
Total ▲	26.25	23.69	23.11	23.37	23.77
Inpatient Hosp ▲	3.19	3.05	2.98	2.95	2.93
Outpatient Hosp ▲	1.10	1.00	0.90	0.89	0.88
Physicians ▲	1.41	1.53	1.51	1.63	1.76
Drugs ▲	1.11	1.13	1.15	1.16	1.18

Units in Millions of services

Medicaid Program

Closing Summary:

The need to contain Medicaid and all health care costs while continuing to provide quality care is a tremendous challenge. To achieve this delicate balance, Montana's Medicaid Program must continue to play a vital role in state health care reform. It can contribute strategies based on years of experience as a major purchaser of health care and an innovator of cost-effective delivery systems like home and community based services and managed care.

As Medicaid continues to be debated in the rapidly changing health care market, we hope this report will help you to understand the Medicaid Program better and will help strengthen the process for changing the program to meet the challenges of the future.

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